Introduction to Art Therapy

Sources & Resources

ROUTLEDGE

JUDITH A. RUBIN

SHOUT
SHARE
IT

Introduction to *Art Therapy*

Introduction to Art Therapy

Sources & Resources

JUDITH A. RUBIN

"It Is Only in Being Creative
That the Individual
Discovers the Self."

D. W. WINNICOTT

Routledge
Taylor & Francis Group
New York London

Routledge
Taylor & Francis Group
270 Madison Avenue
New York, NY 10016

Routledge
Taylor & Francis Group
27 Church Road
Hove, East Sussex BN3 2FA

© 2010 by Taylor and Francis Group, LLC
Routledge is an imprint of Taylor & Francis Group, an Informa business

Printed in the United States of America on acid-free paper
10 9 8 7 6 5 4 3 2 1

International Standard Book Number: 978-0-415-96093-9 (Hardback)

For permission to photocopy or use material electronically from this work, please access www.copyright.com (http://www.copyright.com/) or contact the Copyright Clearance Center, Inc. (CCC), 222 Rosewood Drive, Danvers, MA 01923, 978-750-8400. CCC is a not-for-profit organization that provides licenses and registration for a variety of users. For organizations that have been granted a photocopy license by the CCC, a separate system of payment has been arranged.

Trademark Notice: Product or corporate names may be trademarks or registered trademarks, and are used only for identification and explanation without intent to infringe.

Library of Congress Cataloging-in-Publication Data

Rubin, Judith Aron.
Introduction to art therapy : sources & resources / by Judith A. Rubin.
p. ; cm.
Rev. ed. of: Art therapy / Judith Aron Rubin. c1999.
Includes bibliographical references and index.
ISBN 978-0-415-96093-9 (hardback : alk. paper)
1. Art therapy. I. Rubin, Judith Aron. Art therapy. II. Title.
[DNLM: 1. Art Therapy. WM 450.5.A8 R896i 2009]

RC489.A7R834 2009
616.89'1656--dc22 2009010661

Visit the Taylor & Francis Web site at
http://www.taylorandfrancis.com

and the Routledge Web site at
http://www.routledgementalhealth.com

Contents

	Preface	xiii
	Acknowledgments	xxi
	A Few Words About Style	xxiii
	Introduction to the Revised Edition	xxv
1	Previews	1
	The Many Faces of Art Therapy	1
	Preview of Coming Attractions	1
	Short Stories—Vignettes	1
	How Art Helped Me at Times of Trauma	3
	Art Helps a Psychotic Boy Return to Reality: RANDY (12)	5
	Art Contains Aggression at Home: JENNY (5), NONA (4), and JON (4 and 14) (DVD 1.9)	6
	Stories from the Art Therapy Studio (DVD 1.10)	7
	Art & Drama Therapy Help a Girl Say Goodbye: LORI (5)	9
	Art Therapy Unblocks Grieving for a Little Boy: JEFF (6)	11
	Art Therapy Releases a Worried Boy's Energy: ALAN (4 and 11)	11
	Art Therapy Allows an Anxious Boy to Feel Secure: JACK (12)	12
	Art Therapy Helps a Talented Teenager: BETTY JANE (14)	14
	Art & Drama Therapy Liberate a Depressed Adolescent: JIM (17)	14
	Art Therapy with a Depressed Woman: MRS. LORD (27)	16
	Art Draws out Despair in Marital Therapy: MR. & MRS. T.	19
	Art and Writing Help in Adjusting to a Painful Reality: MARJORIE (45)	21
	Preview of Coming Chapters	24
2	What Is Art Therapy?	25
	Art + Therapy = ?	25
	Art Therapy: What It *Is* and What It Is *Not* (DVD 2.1)	26
	Art Therapy and Art Education (DVD 2.2)	28
	Invisible Differences	28
	Participants "Know" the Difference	29
	Art Therapy and Art for People with Disabilities (DVD 2.3)	31

Educational and Recreational Settings 31
Medical and Rehabilitation Settings 33
Medical Art Therapy and Arts Medicine (DVD 2.4) 34
Room for All: Teamwork (DVD 2.5) 35
Art Therapy and Child Therapy (DVD 2.6) 37
Play Therapy and Child Art Therapy 37
Pediatric Art Therapy and Child Life Programs 38
Art Therapy and Art Counseling 38
Other Clinicians Who Use Art (DVD 2.7) 39
Art Therapy and Occupational, Recreation, and Activity Therapy 39
Art Therapy and Others Using Art in Psychotherapy 40
Art Therapy and Expressive Therapies (DVD 2.9) 42
Expressive Arts Therapy Ends Nightmares: CARLA (8) 42
Mixing Modalities in Treatment 43
Sharing and Collaborating 44
Training Issues 45
Choosing a Multimodal Approach 46
Concluding Thoughts 47
Art + Therapy = Art Therapy 47
Endnotes 48

3 History 49
The Sources of Art Therapy 49
Natural Beauty is Soothing 49
Creating Comes Naturally 50
Art for Healing Is Ancient and Universal 50
Art Therapy: An Idea Whose Time Had Come 51
Psychiatric Interest in Patient Art 51
Interdisciplinary Exchange 52
Creativity and Madness 53
Art Brut and Outsider Art 53
Art in Diagnosis and Therapy 53
Therapeutic Art Education 54
Artists in Hospitals 56
Art Therapy Is Born 57
Naumburg and Kramer 57
Other Art Therapy Pioneers in the United States 61
Art Therapy in Other Countries (DVD 3.13) 64
Concluding Thoughts 68
Endnote 68

4 The Basics 69
The Art Part 69
Knowing Materials 69
Knowing the Creative Process 72
Knowing Artistic Products 73
The Therapy Part 74
Knowing Development 74
Knowing Psychodynamics 74

Knowing Pathology and Potential 75
Knowing Treatment Planning 75
Knowing the Therapeutic Dyad (DVD 4.2) 75
Knowing the Process of Change in Therapy 76
Necessary Conditions: The Framework 76
A Supportive Setting 76
Physical Conditions 77
Psychological Conditions 77
Doing Art Therapy: The Interface 78
Setting the Stage 78
Evoking and Facilitating Expression 78
Looking at and Learning from the Art Process 78
Working Artistically 79
Basic Principles 80
Selecting Art Therapy 80
Assessment in Planning and Evaluation 81
Evaluating Art Therapy 81
Qualitative Evidence 82
Quantitative Evidence 83
Art Therapy Research 83
The Art Product in Evaluation 84
The Art Process in Evaluation 84
Why Art Therapy? 85
Art Involves the Whole Person 85
Much of Our Thinking Is Visual 85
Memories May Be Preverbal or Forbidden 86
Negative Ideas and Feelings Are More Easily Expressed in Art 86
Art Helps to Face What's Inside: LAURIE (38) 87
Art Offers Unique Possibilities for Expression 87
The Art Product Is a Helpful Presence 88
Art Is Flexible and Versatile 89
Art Normalizes Psychotherapy 89
The Creative Process Is a Learning Experience 90
Art Is a Natural "High" That Also Heals 90
Why Art? 92
Back to Basics 92
Endnote 93

5 Approaches 95
Multiple Paths: Multiple Perspectives 95
Psychodynamic Approaches to Art Therapy 96
Freudian Psychoanalysis 96
Free Association in Art Imagery: LINDA (8) 97
Jungian Analytic Therapy 98
Humanistic Approaches to Art Therapy 100
Person-Centered Approach 100
Adlerian 100
Gestalt 101

Ericksonian 102
Phenomenological 102
Existential 102
Psycho-Educational Approaches to Art Therapy (DVD 5.3) 103
Behavioral 103
Cognitive 104
Developmental 107
Adaptive 107
Systemic Approaches to Art Therapy 107
Family Art Therapy 109
Images Illuminate Important Issues—John and His Mother After Father's Death 110
Group Art Therapy 111
Individual Growth in a Group: DON (9) 112
Art/Image-Based Approaches to Art Therapy (DVD 5.5) 113
Spiritual Approaches to Art Therapy 113
Integrative Approaches to Art Therapy 115
Theory, Technique, and Art Therapy 116
Art Therapists as Theorists 116
The Unspoken Perspective 117
Selective Eclecticism 117
Is Theory Really Necessary? 117
Endnotes 118

6 Assessment 119
Art and Diagnosis 119
Projective Techniques 119
Responding to Visual Stimuli 120
Preference Tests 120
Copying and Completion 121
The Scribble Drawing 121
Projective Drawings 122
Standardization in Drawing Tasks 125
Art and Psychopathology 125
Studies of Artistic Development 127
Art Therapists as Diagnosticians 128
Art Therapists and Projective Drawings 128
Draw-a-Person and Self-Portrait in Assessment: JIMMY (5) 128
Rating Scales by Art Therapists 129
Rating Scales for Art Products 129
Rating Scales for Art Behaviors 130
Assessing Change After Seven Weeks of Group Art Therapy 132
Art Therapy Assessments 134
Overview 134
Unstructured Approaches 134
Art Assessment Reveals Depth of Pathology: EVELYN (16) 135
A Scribble Drawing Helps a Sullen Adolescent: MELANIE (15) 135
Structured Approaches: Themes 135

Art Assessment Batteries: Individuals 136
Art Assessments for Specific Purposes 137
Assessing Sexual Abuse Through Art 138
Assessing Spiritual Development Through Art 138
Art Assessment Batteries: Families 139
Art Assessment Batteries: Couples 139
Selection/Creation Art Assessment Batteries 139
Silver Drawing Test of Cognition & Emotion 139
Magazine Photo Collage 140
Face Stimulus Assessment 141
Concluding Thoughts 141
Endnotes 142

7 Technique(s) 145
Introduction 145
Evolution of Art Therapy Technique 146
Evoking Expression (DVD 7.1) 146
Warming Up 146
Pictorial Stimuli 147
Visual Starters 147
Using the Nondominant Hemisphere 147
Stimulating Materials and Methods 148
Regressive Media Help in Dealing with Shame: GLORIA (29) 148
Mental Imagery 148
A Series of Images 149
Facilitating Expression (DVD 7.2) 150
Motivational Techniques 150
Artistic Interventions 150
Drawing Workbooks and Guides 153
Deciding What to Do and Why 154
Specific Tasks Help a Family to "See" Problems 157
Variations on the Visual Arts 158
Sandplay 158
Hypnosis and Guided Imagery 158
Phototherapy, Videotherapy, and Computers 159
Art and Film Therapy Help a Young Man Grow Up: ISAAC (DVD 7.9) 161
Multimodal Expressive Arts Therapy 163
Concluding Thoughts 164
Endnotes 166

8 People We Serve 167
Art Therapy Is Especially Good For … 167
Those Who Have No Words 167
Those Who Are Resistant 169
Art Therapy With an Elective Mute: ELLEN (11) 169
Art Therapy Is for All Ages 171
Children 172
Art and Sandplay Help a Grieving Toddler: BILLY (2) 172

Art and Play Therapy for an Anxious Little Girl: AMY (3) (DVD 8.10) 174
Adolescents 174
Art Therapy for a Painfully Shy Adolescent: LUCY (13) 176
The Story of Sam: A Schizoid Teenager (18) 176
Adults 179
Art in Diagnosis and Therapy with a Young Adult: SALLY (22) 180
Unresolved Grief Finally Faced: OLIVER (36) 181
Art Therapy for Artists 183
The Elderly 184
It's Never Too Late: HANNAH (64) 186
Endnotes 189

9 Problems We Address 191
Living With Mental Illness 191
Introduction 191
A Story of Bravery and Creative Coping: KAREN 191
Children with Psychotic Disorders 194
A Youngster with Childhood Schizophrenia: DOROTHY (10) 194
A Girl Who Spoke by Shutting Me Out: KITTY (4) 197
A Teenager With Asperger's Syndrome Uses Puppets: EMILY (16) 199
Living With Disabilities 199
A Therapeutic Art Program Helps a Partially Sighted Girl: JANE (11) 200
Expressive Arts Therapy Helps a Blind Boy: LARRY (8) 201
History of Art Therapy for Those With Disabilities (DVD 9.8) 202
The Family of the Disabled Individual 206
Problems Especially Helped by Art Therapy (DVD 9.9) 206
Eating Disorders 207
Art Therapy for an Adolescent with Anorexia: LILA (17) 207
Substance Abuse 207
Art Therapy Helps a Recovering Addict: AMELIA (25) 209
Survivors of Sexual Abuse 209
Dissociative Identity Disorder (Multiple Personality Disorder) 210
From Depression to Dissociation: The Story of ELAINE (40) 210
Is Art Therapy Dangerous for Some People? 215
Concluding Thoughts 216
Endnote 216

10 Places We Practice 217
Introduction 217
Medical Art Therapy 218
Art in Medical Assessment 218
Art Therapy for Psychosomatic Conditions 220
A Child With Encopresis: JERRY (11) 221
Art Therapy in Trauma and Rehabilitation 222
Art Therapy for Healing 224
Art Therapy for Terminal Illness 225
Fighting Cancer With Art and Imagery: SUE (37) 226

Art Therapy for Bereavement (DVD 10.5) 227
A Child Requests Art Therapy After His Mother Kills Herself: CHRISTOPHER (7) 228
Art as Therapy in Times of Crisis 229
War and Combat 229
Natural Disaster and Violence 231
Community Tensions 231
People and Families in Crisis 232
Art Therapy for Posttraumatic Stress Disorder (PTSD): JACKIE (7) 232
Displaced Persons 233
Economically Disadvantaged Individuals 233
Art Therapy in Correctional Institutions 234
Art as Therapy for Wellness 235
Art as Therapy in Everyday Life 235
Art as Therapy for Children and Families 235
Art as Therapy in a Preschool: SAMMY (4) 235
Art as Therapy for Normal Adults 238
Concluding Thoughts 238
Endnotes 239

11 Professional Issues 241
Evolution of Art Therapy Education 241
Becoming an Art Therapist 241
Learning by Doing 241
Learning by Teaching and Consulting 242
Art Reveals Capacities of a Deaf-Mute Girl: CLAIRE (10) 242
Learning by Sharing with Others 243
Learning in Personal Psychotherapy and Supervision 243
Apprenticeships, Courses, and Training Programs 245
Supervision 246
Self-Awareness 246
Images of Supervision 247
Promoting Creativity in the Art Therapist 247
Becoming an Art Therapist: Professional Identity Formation 248
Evolution of Standards 249
Standards for Registration 249
Standards for Board Certification 250
Standards for Educational Programs 250
Evolution of Continuing Education 250
Learning Through Further Education 250
Obtaining Relevant Credentials 251
Ethics in Art Therapy 251
Standards of Practice and Ethical Conduct 251
Ethics and the Art Created in Art Therapy 252
Ethics and Client/Therapist Differences 253
Disability Issues 253

Phenomenological Research on a Tactile Aesthetic 254
Multicultural Issues 255
Evolution of Political Action and Networks 258
Public and Professional Awareness 259
Concluding Thoughts 260
Endnotes 261

12 What Next? 263
Finding Out More About Art Therapy 263
Growing Art Therapy Literature 264
Art Therapy as a Career 266
Reality Check: Jobs and Salaries 266
Credentialing in Other Areas 267
New Employment and Funding Sources 267
The Future of Art Therapy 270
Art Therapist Predictions: Past and Present 270
Art Therapy Has Much to Share 271
Art Therapy in the Age of Virtual Reality 273
Artist or Therapist? 274
Need for Art in Times of Change 274
Art + Therapy = Art for Life 275
Endnotes 275

Resources 277
References 281
Introduction to Art Therapy: Sources & Resources 297
Index 317

Preface

Art as a helper in times of trouble, as a means of understanding the conditions of human existence and of facing the frightening aspects of those conditions, as the creation of a meaningful order oȧering a refuge from the unmanageable confusion of outer reality—these most welcome aids are grasped by people in distress and used by the healers who come to their assistance.

Rudolf Arnheim

Map of the Territory

This second edition of a book written a decade ago reflects my wish to bring its contents up to date in a field that continues to grow at an amazingly rapid rate. This growth is reflected most dramatically in two areas that were beginning to be apparent when the first edition was finished in 1997, but are increasingly evident a decade later.

The first is an exponential increase in the literature, reflected in the number of books cited in the References, almost twice those noted only ten years ago. Increasingly specialized, they are often edited or written by multiple authors, indicating an awareness of the complexity of the particular knowledge and skills required to conduct art therapy with different sorts of individuals in diverse settings. This is true whether the content to be mastered is the nature of particular disorders, the cultures within which practitioners work, or the latest developments in attachment theory, neurobiological development, and ways of reconceptualizing therapeutic paradigms (Jones, 2005; Riley, 1999, 2001). The literature also reflects a growing level of sophistication about both psychology and art (Maclagan, 2001), and a thoughtfulness not always apparent in the past. It has become more profound, at the same time more poetic, and, paradoxically, more pragmatic.

The second is an awareness and acceptance of the idea of art therapy in mental and physical health care, as well as in the culture at large. As with psychoanalysis, whose concepts have permeated our society, there is often considerable misunderstanding. While the pervasiveness of the notion that art can be healing is a testament to the success of the profession embodying this idea, it has also created confusion because of the different kinds of people who offer therapeutic arts activities.

For this reason, Chapter 2, which deals with the definition of art therapy, may be even more pertinent in the 21st century than it was in the 20th. Since art therapy is indeed an idea whose time has come, the history of the discipline in Chapter 3 is not only timely, but also essential for a comprehensive understanding of the profession. The spread of art therapy around the globe is an impressive phenomenon, which will no doubt continue in this era of instant and easy communication.

Ten years ago I was persuaded to write the first edition of this book because I agreed with my editor that there was a need for an introductory text that would provide a fair and accurate overview of the field. In the decade since then, two books have been published which led me to wonder whether this text was still needed. However, after looking carefully at each, I believe that the two recent books are complementary, but not identical to the mission of this one.

It is probably no accident that both are entitled the *Handbook of Art Therapy,* and because they hope to introduce readers to many ways of working and thinking, both cover some of the same territory as this text. One (Malchiodi, 2003) is an edited collection of chapters by different specialists about particular subjects. The other (Case & Dalley, 2006) understandably reflects the way in which art therapy has developed in the United Kingdom, which is similar to, but different from, how it has evolved in the United States (Gilroy & McNeilly, 2000).

After serious consideration, I concluded that an overview of the field by a single author is still a good idea, especially because of art therapy's continued growth and development during the past decade. My goal remains the same: to make this text broadly inclusive and reflective of the rich past and present of this new discipline. My aim has been to review and to distill the story of this still-evolving profession. Looking at the past as well as the present has been greatly encouraging, since art therapy continues to grow, not only in size and scope, but in sophistication as well.

It is my wish that, despite its necessary brevity, this book will be sufficiently informative that the reader will want to explore the discipline in more detail, going to some of the more specialized literature noted in the chapters and listed in the References. My plan is to broadly outline the history and current shape of the field, and my hope is to do so in a way that is both fair and accurate.

This book is something like an *aerial map* of the territory, to be further explored at ground level by the interested traveler. As with a map, the reader may explore specific areas (chapters) in whatever order is most appealing, since they are essentially independent of one another.

Getting to know a person or a profession takes time. It is always risky to generalize from insufficient data. A little knowledge, in art therapy as elsewhere, can be a dangerous thing. And a little knowledge *about* art therapy is just that, only one aspect of a multifaceted discipline, with almost as many possible permutations as there are practitioners. No single instance represents the whole, yet each is part of a richly varied panorama. Hopefully, the overview provided in this book will give the reader an orientation with which to further explore this fascinating field.

Perspectives: Personal and Historical

In addition to providing an overview, I have attempted to give the reader a feeling for the drama of art therapy's evolution, as well as an introduction to some of the key players. Since I have participated in the development of the profession in a variety of ways, I shall include some personal experiences, when and if it seems that they illustrate the story of art therapy.

On the **DVD (0.1)** you can watch "My Life in Art Therapy," in which I briefly outline my own experiences, some of which are described further in later chapters.

I believe strongly that the shape of the present can best be understood in the context of the past. Whatever kind of knowledge you want to acquire, knowing what came before is extremely useful. In psychotherapy itself, clinicians differ greatly about the need to deal with the past in the treatment. But all agree that some kind of *history* is vital to developing a sense of the problem and of possible solutions. Even cognitive-behavioral therapists, whose focus is on the here-and-now, need to obtain what they call a *baseline* before initiating the process of therapy. For this reason, many chapters include early work as well as current thinking and practice.

This volume can offer the reader breadth, but it cannot provide depth. Missing is the intimacy and immediacy of what actually goes on in art therapy, especially over time. The brief clinical vignettes included here offer but a glimpse of the drama of the treatment situation. Even the longer stories in this book are mere summaries of a richer and more nuanced process. There are, however, more substantial case studies in the literature, which the reader can explore to get a sense of the unpredictable narrative of a creative therapeutic adventure. These will be referred to within the chapters.

Words and Pictures

In addition to the story of each individual, family, or group in art therapy, there is the powerful nonverbal drama of the moment-to-moment encounters among patient(s), therapist, and art materials. I believe that the dance that ensues is best illustrated through the medium of film. I had planned to create a videotape to accompany the first edition. Because a change of publishers led to the abandonment of that plan, I ended up creating a film overview of the field of art therapy, which is independent of this volume but is a useful supplement. A recent review in an art therapy journal said of the film, "It really tells you everything you need to know about art therapy."*

Art Therapy Has Many Faces (Rubin, 2008a) is a visual introduction to the field, and has been remarkably successful for an educational film. At the time of this writing it had sold over 2,500 copies with no advertising or promotion, simply by word of mouth, and a version with Chinese-language subtitles is being distributed by the Taiwan Institute of Psychotherapy. This suggests that it has met a need, which cannot be met by words alone. For that reason, it is recommended that the reader obtain a copy of the film from Expressive Media, Inc. and use it as a supplement to this text (www.expressivemedia.org).

As the Art Lady on the public television program *Mister Rogers' Neighborhood* during its first three years, I was introduced very early to the power of the media. After that experience, and with Fred Rogers' encouragement, I made three teaching films (Irwin & Rubin, 2008; Rubin, 2008c, 2008d) and was instrumental as a board member of the American Art Therapy Association in recording four pioneers in *Art Therapy: Beginnings* (American Art Therapy Association [AATA], 1975).

This is because it has always seemed to me that only in vivo could the therapeutic power of art be effectively communicated. The very elements that make art therapy so effective are difficult—if not impossible—to fully convey in words, even with pictures of the creative process and the artwork created.

---

* Burt, H. Video review. Canadian Art Therapy Association Journal, 20(2), 2007: 54.

Expressive Media, Inc. (EMI, www.expressivemedia.org), a nonprofit organization founded by my drama therapy colleague and me in 1985, now distributes not only *Art Therapy Has Many Faces*, but also remastered versions of our early films with special added features on each DVD (Irwin & Rubin, 2008; Rubin, 2008a, 2008b). In addition, EMI distributes a remastered version with related features of *Beyond Words: Art Therapy for Older Adults,* a film originally sponsored by the American Art Therapy Association to inform legislators about the healing power of art (Rubin, 2008b).

In the years since the first edition was published, the world has seen many changes in communication patterns, thanks to the computer and the Internet. People are learning more and more through electronic avenues. I am pleased that Routledge agreed to include a DVD in this second edition, which will allow the reader to see many more of the images referred to in the book. Compressed video files have also been included on the DVD to be played on a computer. These, though brief, serve to illustrate the text more dynamically than any still photograph can ever do.

Because it is essential that the reader be able to locate specific images and video clips while using the book, the *Contents of the DVD* is available as a text file on the disc, to be printed out for easy reference. These specific images are also referred to in the text itself in **bold type.**

Expressing and Reflecting

In a way, the complementarity of film and images with the text of this book parallels the nature of art therapy itself. The combination of genuine expressive art activity **(Figure 1)** with some kind of thoughtful reflection on that process **(Figure 2)** is really the essence of this field. In fact, it is what distinguishes it most clearly from related disciplines.

In almost all approaches to art therapy, there is an image-making time and a reflection time. The proportions may vary, and the thoughtful component may be silent, and can involve movement, music, drama, and poetry, as well as written or spoken verbal

Figure 1 A woman involved in creating.

Figure 2 The same woman looking and reflecting.

Figure 3 A blind boy involved in finger painting.

commentary. Art therapy, however, always includes involved doing **(Figure 3)** plus relaxed reflection **(Figure 4)**, with or without words.

This combination, like psychotherapy plus medication for depression, is more powerful than either one alone. Creating art can indeed be therapeutic, and verbal therapy can be very effective. But there is something about the two together that is really spectacular. Of

Figure 4 The same boy talking about the experience.

course, there are times in art therapy when expressing or reflecting is the focus of a particular session or period of time, but the discipline by definition includes both elements. As with most alloys and hybrids, the synergistic mix is sturdier than the individual elements alone.

Seeing and Doing

Although a film or an image can offer useful illustration, there is nothing like observing an actual session for finding out what art therapy is all about. Even better than watching is participating. This kind of active personal engagement in learning may also occur in a workshop experience or in treatment—as an individual, as a member of a group, or as part of a family. Nothing conveys the power of art therapy as much as doing it, even if it is no more than a brief involvement.

Some of the recent books in the field include suggested art activities and exercises to extend the experience of reading about art therapy. Although it would be possible to add that component, I am more comfortable recommending that the reader attend a workshop given by someone who can create a safe environment to hold what emerges.

Art Therapy: A Rapidly Growing Hybrid

I am convinced, in fact, that it is the synergistic potency of the combination of art with therapy that accounts for the rapid growth of this still-young field. This is especially remarkable, because recent years have seen economic belt tightening in all kinds of institutions that educate and employ art therapists in the United States. Although the rate of growth has fluctuated, the field has been steadily expanding. New training programs and job opportunities have continued to develop, most often through the creative efforts of individual art therapists and others who believe in its potential. The professional association in this country has grown since its founding in 1969 from a membership of 100 to 5000. And, as noted earlier,

there has been a worldwide expansion of the field of art therapy, with pioneers and new programs appearing around the globe.

Although I imagine that the majority of readers are likely to be students of art therapy, I hope that others will read this book as well. For if more administrators, colleagues, and concerned citizens were aware of the power of art in therapy, I feel certain they would want to promote it. Perhaps even a brief introduction to this rich and wonderful discipline will stimulate the development of opportunities for more people in more places to have access to the healing power of art.

Judith Aron Rubin

Acknowledgments

Many have helped in the work on this book; I can express my gratitude to only a few. I was astonished to find that approximately 200 books on art therapy and related areas had been published in the decade since I wrote the first edition. I am grateful to my publisher, Routledge, for making its books on art therapy available to me. My special appreciation to Jessica Kingsley for her generosity in allowing me to obtain her many recent publications in the field at a price that a retired professional can afford, and my thanks to Charles C. Thomas for a discount on its recent books.

There are many individuals to whom I am grateful for their work on the photographs that illustrated the first edition of this book, some of which are on these pages, while others are now found on the DVD. Most of the illustrations are from my own files and were shot by Norman Rabinovitz and Sheila Ramsey of Children's Hospital or by the Media Services of Western Psychiatric Institute & Clinic. In addition, some of the photographs, such as the picture of Edith Kramer with Eleanor Roosevelt by Herschel Stroyer, and the one of Bruce Moon by George Pugh, were taken by freelance artists. Several images were taken by the late Jacob Malezi, a few were photographed by Richard Hurst, and some were donated by Lynn Johnson.

Pictures of the pioneers were generously provided by art therapists from their own records or the archives of others. My thanks to: Gladys Agell, Frances Anderson, Robert Ault, Sandra Graves, David Henley, Don Jones, Cliff Joseph, Edith Kramer, Mildred Lachman-Chapin, Myra Levick, Bruce Moon, Aina Nucho, Arthur Robbins, Mary Cane Robinson, Rawley Silver, Patricia St. John, Harriet Wadeson, Christine Wang, and Diane Waller of Goldsmith's College in London.

Thanks to the Van Pelt Memorial Library of the University of Pennsylvania for photographs from the Margaret Naumburg Archives, and to Tom and Kate Frank for pictures of Ms. Naumburg, who was Dr. Frank's mother. Thanks also to the Archives of the Pennsylvania State University, and to John Michael, Alice Schwartz, and Ed Mattil for pictures of Viktor Lowenfeld. Thanks as well to Nancy Knapp of Emporia State University and the AATA Archives, for photographs of Florence Cane and Mary Huntoon. Thanks to Monika Smith of the Zierer Archives at the College of New Rochelle for pictures of Edith Zierer. Because of the DVD, it has been possible to include images of many more colleagues in this edition. They are too numerous to list here, but all are identified in the Contents of the DVD.

As for the written part, I thank Natalie Gilman, my first editor on this project, for talking me into it, my colleague Laurie Wilson, who helped me to outline the first edition, and to Ellie Irwin and Laurel Herman for helping me to refine its language and organization. I am indebted to the reviewers who critiqued the first edition, and whose comments were most helpful in revising the text. I want to especially thank Randy Vick, faculty member and former Chair of the Master of Arts in Art Therapy program at the School of the Art Institute of Chicago, whose detailed suggestions made this revision considerably easier.

My appreciation also goes to those who reviewed the first draft of this manuscript for their suggestions. I am deeply grateful for the help of the many art therapists and others in allied fields I wrote or called with questions and requests, who are too numerous to name, but who were uniformly gracious and responsive. I am also indebted to my Editors at Routledge, George Zimmar and Fred Coppersmith, who have been extraordinarily patient with my tardiness in getting this manuscript to press. Their understanding and graciousness with the delay has been appreciated.

Of course, I could never have written this book at all without my very best teachers—the patients, students, supervisees, consultees, and colleagues—from whom I have learned over the past 45 years. My gratitude for what they have taught me goes beyond words.

A Few Words About Style

Before getting into the text, I should like to explain some stylistic decisions . . . Since the vast majority of art therapists are women, I have chosen to use the female pronoun when talking about the therapist. Although patients are of both genders, I have arbitrarily chosen to use the masculine pronoun when referring to them in a general fashion. I hope this decision will not mislead or offend the reader, since it seems to make for a smoother flow in the text. While I have tried to be "politically correct" in terminology, I apologize in advance to anyone who feels offended by my preference for language that is familiar to me.

Introduction to the Revised Edition

After writing the first edition of this book (Rubin, 1998), I began work on a film overview of art therapy (Rubin, 2008a) and completed a revision of *Approaches to Art Therapy: Theory & Technique* (Rubin, 2001), first published in 1987. Because changes in theory and practice were happening so rapidly, the second edition of *Approaches* contains six new chapters by additional contributors, as well as commentaries on the chapters in each section by six other distinguished colleagues.

Meanwhile, having spent a good deal of my past and current teaching career instructing trainees in psychiatry, psychology, and social work, I published a book entitled *Artful Therapy* (Rubin, 2005a) for non-art therapist mental health professionals. Since they are increasingly interested in using art, imagery, and other creative modalities in their work, but often have little assistance, it was my feeling that they would be more successful with a bit of advice on how to do so effectively.

I also did a second revision of my first book, *Child Art Therapy* (Rubin, 2005b), which came out in 1978 and was first revised in 1984. The third edition is twice as thick as the second, since there is a considerable amount of new material based upon the suggestions of reviewers who had used the book in teaching over the years. For both of these latter books I created accompanying DVDs like the one in the back of this book.

The main reasons I wanted to revise this book were to update the content, as well as to add a DVD that contains a much richer illustration of what is in the text than is possible with figures alone. Because I wanted this volume to be a substantive resource for students and professionals, I have noted a great many books and have made reference to the work of numerous art therapists. I have also attempted to enliven what might otherwise be a rather dry enumeration of resources in two ways. One is the inclusion of more clinical vignettes than in the first edition, and the other is the DVD.

The DVD has over 400 still images (most of them in color) and about 250 brief edited video clips. Even though they have to be compressed in order to fit on the DVD, which means they are not as sharp as the originals, the video segments can bring the text alive in a way that still images cannot. It is also recommended that readers purchase *Art Therapy Has Many Faces* (Rubin, 2008a), a separate DVD that covers most of this book's contents in a more vivid and lively way, and which can be played in a DVD player and projected on a

large screen (www.expressivemedia.org). It, too, is an overview of the field, and in fact began as an accompaniment to the first edition of this text.

Although only a decade has elapsed since the first edition, the literature in the field has increased exponentially, while the profession has become much better known and accepted. This has resulted in a number of changes that need to be understood and clarified for art therapists as well as for others. Because an awareness of "art therapy" as an idea has become part of our culture, this success has also bred confusion.

Art therapy is a unique profession, in that it combines a deep understanding of art and the creative process with an equally sophisticated comprehension of psychology and psychotherapy. It seemed therefore imperative at this historical juncture to clarify the differences between artists or teachers who provide "therapeutic" art activities, psychologists or social workers who request drawings in their work, and those who are trained as art therapists to do a kind of work that is similar, but qualitatively different. As I worked on this second edition, that need for clarification seemed at least as important as the need to update the content.

The organization and structure of the book have been altered in a variety of ways. Several modifications were suggested by the reviewers, to whom I am most indebted. In balancing what might be omitted against what needed to be added, I have also been guided by the limitations of space.

Changes from the First Edition

Because there is now a DVD accompanying the book, I omitted the introduction of pioneers with photos in the first chapter. This had been a way of trying to say in black and white that "Art Therapy Has Many Faces," a goal that I believe is accomplished much more effectively and colorfully in the film with that title (Rubin, 2008a). However, because that film conveys only moments, rather than change over time, I decided to expand the clinical vignettes in this book, to add some more, and to include some longer ones that tell the story of individuals' treatment over time.

In the "Previews" chapter (Chapter 1) I have enlarged the portion where I shared with the reader my own introduction to the therapeutic power of art—as a person, as a worker, and as a parent. This chapter also includes examples of work with different children, adolescents, and adults. Chapter 2, on the definition of art therapy, has been expanded and updated, as has the third chapter on the history and present development of the field.

Chapter 4, "The Basics," now includes a section on treatment planning and evaluation, also part of what art therapists need to know. It is followed by Chapter 5, "Approaches," and Chapter 6, "Assessment," both of which have been modified and updated.

Where there were two chapters describing the work that art therapists do, there are now three (Chapters 8, 9, and 10): "People We Serve" (all ages), "Problems We Address" (different disorders and disabilities), and "Places We Practice," especially the new settings that represent the expansion of art therapy beyond its original home in psychiatry.

The material in the chapter on Education (originally Chapter 4) has been shortened and is now found in Chapter 11, "Professional Issues," where it is combined with updated information on standards, ethics, and informing others. "What Next?" is a question for both individuals and the profession, and is the subject matter of the final chapter. It is followed by a list of resources (selected professional associations and proceedings) and references—books on art therapy and related areas.

In the first edition I tried to save space by artificially shortening citations, which readers found distracting; this edition, therefore, uses APA style for footnotes and references. In the first edition I referred to some published work (pamphlets, for example) that was not easily accessible and was therefore frustrating to readers. In this edition, I have restricted citations primarily to books that can be purchased or borrowed on interlibrary loan, referring to journal articles and pamphlets in footnotes. Finally, the title has been modified to reflect the fact that, while the book is primarily an *Introduction to Art Therapy*, it is also a place to explore the historical context as well as the present situation, that is, the profession's *Sources & Resources*—the new subtitle.

CHAPTER 1

Previews

The Many Faces of Art Therapy

What does art therapy look like? Art therapy is, always has been, and will continue to be a multifaceted field. There are a multitude of ways in which art can be used for either understanding (assessment) or for helping (therapy). But art therapy is a paradox—it is both extremely old and very young. Art for healing is as ancient as the drawings on the walls of caves **(DVD 1.1)**, yet the profession itself is still a youngster in the family of mental health disciplines. Art therapy is both primal and sophisticated, since making pictures appeals to a range of creatures, from apes **(Figure 1.1)** to artists **(DVD 1.2)**. Because art therapy is also extremely versatile, it has many different faces. This is dramatically visible throughout the film, *Art Therapy Has Many Faces* (Rubin, 2004a).

Preview of Coming Attractions

Some years ago, I saw a little girl and her mother for individual art therapy, in tandem with a child psychiatrist who also met with each of them weekly. Lori **(DVD 1.3)** would come into my art room, while Mrs. Lord **(DVD 1.4)** saw Dr. Mann for 45 minutes. They would then switch places as well as therapists. Afterward, Dr. Mann and I would meet and look at the pictures or sculptures done by Lori and her mom during their art sessions. Because ideas and feelings would appear in their art long before they were expressed in play or verbal therapy, Dr. Mann used to say that art therapy gave him a "preview of coming attractions."

Art therapy is vital for those who cannot or will not talk, like aphasic or electively mute individuals. At the same time, it is extremely helpful for people of all ages, even those who are verbally articulate. Art helps people like Lori and her mother to "see" what they are *feeling or thinking.* Art therapy can aid artists and non-artists alike, whether they are fluent or blocked. On the **DVD (1.5)**, a woman describes this kind of discovery process.

Short Stories—Vignettes

In order to give the reader a sense of what happens in art therapy, I begin with some brief vignettes describing in words the essence of why the field exists and continues to grow. Art

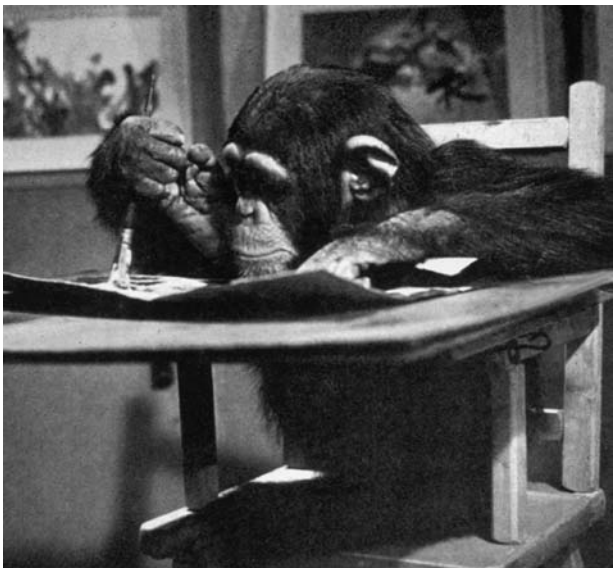

Figure 1.1 Congo painting.

therapy depends on the inherently therapeutic power of art, which is available to anyone who paints or draws or sculpts. It is likely that most people who decide to make it their life's work have personally known its healing potential, and I am no exception. For this reason, the initial vignettes recount my own experiences. They describe how making art at critical moments helped me to cope with my anguish after the death of a friend when I was a teenager and of my mother when I was an adult.

The second vignette tells about my initial discovery of the power of art to help severely disturbed youngsters in my very first experience as an art therapist, in 1963. Since I had not yet had any formal clinical training and worked in a nondirective manner, I was astonished by the power of making art in an accepting, nonjudgmental environment to help youngsters with childhood schizophrenia express and work through their conflicts.

The clinical psychologist who was supervising me was equally astounded, as was the staff on the unit where these youngsters were hospitalized. I was invited to present my work in Grand Rounds at Western Psychiatric Institute & Clinic where the special treatment unit was housed. Harvard Professor Erik Erikson (1950, 1977), himself a painter prior to becoming a psychoanalyst, commented on all of the presentations about the case being discussed. He had no hesitation in suggesting that it was primarily in art therapy that the child was making progress in coming out of her psychotic isolation, a story that will be told in Chapter 9 (Dorothy, **DVD 9.3)**.

The third group of vignettes is about my own children because, as our family grew, my beginning-art-therapist self became aware of how useful art expression was for them as a way of dealing with feelings and impulses that were difficult to manage. These personal discoveries about the helping power of art are followed by some examples of work with individual children, adolescents, and adults in an outpatient clinic and in my private practice. They are included here to indicate, despite their brevity, how work in the context of a trusting relationship with a (by then) trained art therapist can promote change. Like the "short cuts" from a film, they offer a taste of what art therapy is all about. Although the names have been changed, the stories are true.

How Art Helped Me at Times of Trauma

Sometimes making art became, for me as for others, a way of coping with trauma, events that are too difficult to assimilate **(DVD 1.6)**. When I was 17, my friend Peter suddenly died. He had been young, handsome, and healthy, president of our class, ready to go on to a bright career in college and the world. And in a crazy, senseless accident at high altitude, he stepped off the edge of a Colorado mountain and crashed to his end. Numbly, I went home to the funeral, then returned to the camp where I was working as an arts and crafts counselor, and then succumbed to a high fever for several anguished days and nights.

When I awoke, I felt a strong need to go to the woods and paint. On my first day off I did, and it was good. The painting was not of Peter, but of a person playing the piano, making music in dark reds, purples, and blacks. It was a cry, a scream caught and tamed **(A)**. It was a new object in the world, a symbolic replacement for he who was lost, a mute, tangible testament. The doing of it afforded tremendous relief. It did not take away the hurt and the ache, but it did help in releasing some of the rage, and in giving form to a multiplicity of feelings and wishes.

So too with a remembered nightmare, finally drawn and then painted, given form and made both more beautiful and less fearful **(B)**. Years later I was to discover, much to my surprise, that drawing a dream would help my daughter to finally sleep in peace **(C)**. It was she who asked if I might help her the way I helped other children at the clinic. How wise she was, since the dream did not recur after she drew it.

Over time I began to understand the mechanism, the dynamics, the reason behind this miracle of taming fear through forms of feeling. I think it is what the medicine men have known for so long, that giving form to the feared object brings it under your own symbolic control. This simple but powerful truth underlies much of art therapy.

Waking as well as sleeping fantasies evoked images that invited capture on canvas. A powerful, insightful revelation of ambivalent feelings toward my formerly idealized mother during my analysis stimulated a rapidly done expressionistic painting, which still evokes tension when I view it **(D)**. As an externalization of how and what I was feeling, however, it gave both relief and a greater sense of understanding. The push and pull of conflict was translated into paint, reducing inner anguish through outer representation.

Many years later, stimulated by my psychoanalytic training, I was intrigued by the idea of "free association in imagery." An artist friend and I decided to offer a class through the Psychoanalytic Center, in which participants would be invited to choose a medium, and then to let each emergent image follow the last, until the sequence felt complete. Modeled on the basic "method" of free association in analysis, it turned out to be amazingly powerful **(Figure 1.2)**. For myself, the Imaging course came at a stressful time; the first class was a week after my mother's unexpected death. I found it surprisingly helpful to my own mourning process to engage in a freely associative use of materials. A review of the drawing series that emerged that day may help you to understand how therapeutic a series of spontaneous images can be, even without discussion **(DVD 1.7)**.

The first, red and black, sharp and angular, felt like "Pain" **(A)**, and was tense and angry in the doing. The second became "My Mother in the Hospital Bed" hooked up to the oxygen tank **(B)**, as I had last seen her alive the week before her demise. I was surprised at how much she looked like an infant. The third began abstractly, but became a pair of breasts with large dark nipples. I titled it "Mama-Breast-Love" **(C)**. The fourth is a child reaching up to a mother who is mostly a smiling face. When I looked at it I thought it was me saying "I Love You, I Need You" **(D)**.

Figure 1.2 Participant in Image Association workshop reviews artwork.

The fifth began as a stark, angular tree, then an image of a tombstone, and then I thought of sun and eyes shining, looking down from above. "Can You See?" **(E)** was the title that came to mind, the prelogical, wishful/fearful magical thinking that had been flowing through my usually skeptical head. The sixth was an image of my mother and (already dead) father meeting in some other life; he welcoming her, the two "Together Again" **(F)**—another magical thought.

The seventh arose from intense affect, a feeling of tension and pain, first expressed in the heavily scribbled red and black lines, then in the face that emerged in tears, mouth open, hungry, and angry, "Screaming" **(G)**.

The next image began as a bleak white and gray landscape, then a night sky with a moon and a star, each of which got covered over. Then I thought of a droopy lonely figure—our eldest daughter, far away in France, having to bear her pain separated from the family—and then the thought of the rest of us (my husband and two other children) leaning sadly on each other: "Cold and Lonely" **(H)**. The ninth was a kinesthetic impulse to make tangles of different colors; the title-thought was "All Together" **(I)**.

The tenth began as a wavy line tree on the left, then a wavy line in the center that turned into a dance, which then turned into a person with a large glowing womb inside, then a thought of a baby in that womb. When that image "came" in a kind of "birthing" process, I felt relieved of much of the tension I had experienced throughout the others, as if something had been, at least for the moment, eased. My thought on looking at it along with the others was "Mom-Inside Forever" **(J)**, certainly one way to cope with loss.

While I can easily share my thoughts about the images, it is more difficult to put into words my emotional experience of the process. A similar experience took place the following

week with clay, the next with paint, then with collage, and with the final week's product—for me, a painted portrait of my mother.

I was not aware of "thinking" in the usual sense, but of allowing myself to be led by the materials and my impulses. Each image came quite naturally, almost always with heightened emotion. There was a feeling of activity and internal tension, though "absorption" fits it better, and a sense of being "done" at the end. I did not feel particularly involved in the products as art; indeed, I found them unappealing aesthetically. But I did feel intense involvement in what may have been a kind of "visual thinking" process.

Most significantly, perhaps, I found the entire set of experiences to be extremely helpful in the work of mourning. Instead of the class being a burden as I had feared, it became a welcome respite for me, a chance to deal wordlessly with my grief. I believe that the use of media provided much more than a catharsis. Of course it wasn't the whole story; I remained involved in a grieving process for some time after that class, but I was frankly surprised at how helpful it had been.

Such personal experiences of the power of art in my own life are no doubt what led me to feel so at home in art therapy, and to want so much to make the healing benefits of creative endeavor available to others.

Art Helps a Psychotic Boy Return to Reality: RANDY (12)

My first experience of working therapeutically in art was with children in long-term treatment on an inpatient unit at a psychiatric hospital. Although their diagnostic labels and probable mode of treatment would be different today, they were, and would still be, in considerable psychic pain. What follows is the story of Randy, the most verbal and high functioning of the group **(DVD 1.8)**.

Randy suffered from an embarrassing symptom, soiling his pants, then and now known as encopresis. Although superficially in touch, he was inwardly unsure of the difference between reality and fantasy. Over a seven-month period, Randy had 23 individual art therapy sessions. He began by creating realistic images, like a zebra **(A)** and a fox **(B).** At his seventh session, Randy announced that he didn't want to paint that day, usually his first choice. Instead, he used markers to draw a picture of outer space, with a red planet—"Mars." He added some small yellow "pieces," explaining that they were bits of stars that had exploded. Some were "constellations," specifically "The King" and "The Queen" **(C)**. This drawing led to the creation of a book, *Our Trip Through Outer Space*, which Randy worked on steadily for the next five sessions, making a series of pictures about a Martian and myself in outer space **(D)**.

He then shifted gears for the next four sessions and painted a variety of other topics, such as a castle **(E).** The following week, Randy told me about how people at his school teased him, and painted a picture of fantasized revenge, setting his "School on Fire" **(F)**, then his "Enemies" and finally a Dinosaur with a "Volcano" **(G)**, an apt metaphor for his messy, explosive symptom.

At his next session Randy returned to his space book. He made a cover, pointing out the "new earth," with a portrait of "you wearing one of the newest space hairdos," "your old pal the Martian," and "me [Randy] wearing the newest style in space suits" **(H)**. The following week he painted the Sierra Nevadas with an "ice-capped mountain."

Randy's last five sessions were devoted to an "Earth Series," similar to his "Space Series," but more "down to earth" **(I)**. His oedipal wishes for some sort of romantic relationship with me became clearer in this less-disguised sequence. The Martian dropped out of the story early, and the rest of the book was about our travels around the world. In "Our Visit to Egypt" Randy

Figure 1.3 "Our Trip to Scotland" by Randy.

drew me in "fancy clothes, wearing a see-through dress … and a fancy hairdo." He drew himself giving me the jewels he found when he dug for buried treasure **(J)**. "Our Trip to Scotland" **(Figure 1.3)** shows Randy as an adult holding on to my belt "so you won't trip" **(K)**.

Randy spent his last session reviewing his art in sequence, and was often surprised by pictures he'd forgotten. Best recalled and most liked were the two series, which were also his most careful work. The last one of the earth series was a picture of me on the edge of a cliff in the Philippines **(L),** about which he made up the following story: "A sailor from the *Bounty* was trying to kiss one of the island girls, and she backed off and fell down the mountainside, and then there was a war. The island girls fought the men and the men fought the sailors and the sailors fought the island girls. Everyone fought everyone!" I wondered why the island girl had backed away from the sailor, and Randy replied, "She backed off because she already had a boyfriend." He then quickly drew "The Revolutionary War" **(M)**.

In Randy's two series he created his own symbolic framework, within which he could explore and gratify his curiosity and sexual fantasies regarding his female (mother) therapist. In the course of the story, he was working on resolving what is known as the "oedipal conflict," that is, wanting to win mother, but acknowledging father's position (she "already had a boyfriend"). His impotent rage about losing this competition was at the root of his encopresis. In time, Randy accepted his "defeat," with the help of the therapeutic milieu, the art therapy, and the psychiatrist who saw him for individual and family therapy. As a young adult, he competed with an older candidate for political office, won the election, and was able to enjoy his victory, as well as serve his constituency.

Art Contains Aggression at Home: JENNY (5), NONA (4), and JON (4 and 14) (**DVD 1.9**)

Jenny, our oldest child, was unable to express her jealousy at age five when her brother Jonathan was born. As when Nona had arrived three years earlier, she was a model sister, offering help with household chores and baby care. While Jenny **(Figure 1.4)** was acting equally angelic after Jon's birth, the drawing I found in her room told a more ambivalent story. She had drawn an "Ugly Mommy" and an "Ugly Daddy" who were missing eyes, hair, and limbs, along with a "Beautiful Jenny" **(A)**. The parents, she explained, had gotten ugly by making too many

Figure 1.4 Jenny in art class at the time of Jon's birth.

children. By the time she was six, Jenny was able to include both Jon and Nona in her drawing, although she still put herself on the periphery—and the dog in the attic **(B)**.

Nona, our middle child, was angry with me at age four because I had said she would have to get a haircut if she wouldn't allow anyone to brush her hair. The day her hair was cut, she brought two paintings home from preschool. The first **(Figure 1.5)** was entitled "A Girl Who Has Grown Long Hair and Locked Her Mommy in the Garage" **(C)**. In the second painting, the girl is sitting triumphantly on top of the garage, the mommy (smaller) is still inside, and "The Girl Has the Key" **(D)**. Although Nona couldn't control me in reality, in art she could be more powerful than her mother.

Meanwhile, Jonathan, the youngest child and only boy in the family, also had some problems with aggression. When he was four, he dealt with his scary monster dreams by painting pictures of his fears **(E)**. As he got older, he mastered his impulses through pictorial attacks on family members including his sister **(F)**, his mother **(G)**, and his father **(H)**. Later, he drew armed ships and planes **(I)**, as well as powerful soldiers and superheroes. By adolescence, he was reading science fiction, and thinking of becoming a cartoonist **(Figure 1.6)**, while creating humorous fantasy creatures **(J)**.

Stories from the Art Therapy Studio (DVD 1.10)

These early learning experiences convinced me that art could be therapeutic for all kinds of people, from me and my children to psychotic hospitalized youngsters. In the process,

Figure 1.5 "A Girl has Grown Long Hair & Locked Her Mommy in the Garage."

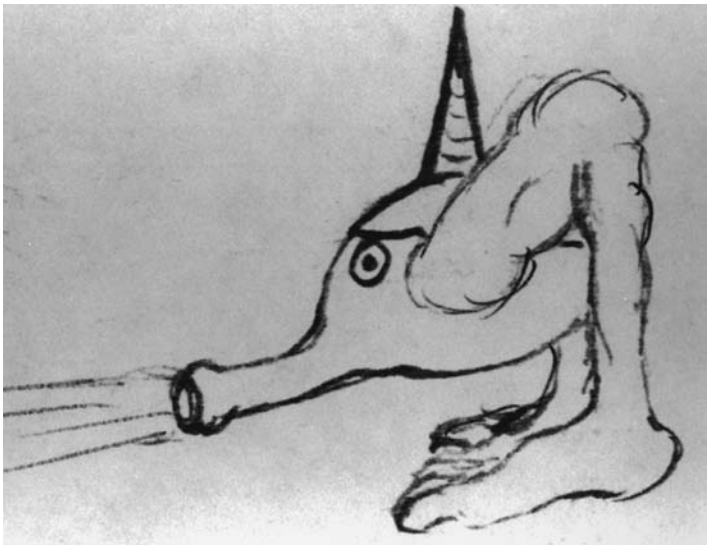

Figure 1.6 A funny creature by Jon.

I discovered that art therapy was the perfect choice for me as well. Some of the following vignettes took place at the Pittsburgh Child Guidance Center, where I worked from 1969 to 1980; some happened on inpatient units served by the Creative & Expressive Arts Therapy Program at the Western Psychiatric Institute and Clinic (WPIC) which I codirected from 1981 to 1985; and some are from my private practice (1974–1997). They are presented in the order of the ages of the individuals involved, since art therapy can be a useful way to help people at all stages in the life cycle.

Art & Drama Therapy Help a Girl Say Goodbye: LORI (5)

This vignette is from Lori's therapy, in which—like most young children—she spontaneously used both art materials **(Figure 1.7)** and dramatic play **(A)**. She was four when her parents separated, and had seen very little of her dad since he had left the house. Although she first left him out of a family drawing, she later added him as the biggest figure in a wishful image of a family picnic. Sadly she said, "I love my daddy. He is beautiful. But he is not a live-at-home daddy."

Several months later, after the divorce, Lori drew a sad girl **(Figure 1.8)**, saying "That girl is crying" **(B)**. In response to my questions she explained that the girl was crying "because her house falled apart … 'cause there was a big, big, storm, and lightning cut it in half." The picture-story was Lori's way of showing how violently her home had been split, how the divorce had been a bolt from the blue, shattering everything in its impact.

Later in that same session, Lori decided on a "new story" for her picture. Grinning impishly, she announced that the crying person was no longer a girl, but a lady … in fact, "You!" She indicated me. I wondered why I might be so sad, and she explained that I was crying "because I left you and I never would come back." Lori used a similar role reversal during her final art therapy session, which took place seven months later.

Figure 1.7 Lori in art therapy.

Figure 1.8 "A Sad Girl" by Lori.

Endings in all therapy, including art therapy, are poignant times, full of the potential for growth that comes with managing a successful separation after a profound attachment. Lori's mother, Mrs. Lord, left some of her artwork with me as a transitional object and for me to remember her; she also took art classes as a way of continuing our work on her own. Lori was even more open about how hard it was to give up her special times with me and with Dr. Mann, to both of whom she had become quite attached. But saying goodbye is one of life's *Necessary Losses* (Viorst, 1986). In art therapy, as in any kind of therapy, it is a powerful experience that, regardless of the length of treatment, is best done when prepared for openly and with the participation of the patient.

Lori's Last Session Lori began by reminding me that it was her last session, announcing that she intended to use some of *everything* in the playroom. After she accidentally spilled some paint, she played at being a bossy mother while we both sponged it up, saying "Do what I say! Don't step in this while it's wet!" Then Lori said that she didn't want to "make believe" that day.

She wondered if I had hidden the ice pick we had used to open clogged holes in paint shakers. When she found it in its usual place, Lori mimed stabbing me with it, saying that she wasn't *really* going to kill me but was only making believe.

Looking at her reflection in the mirror as she often did, Lori proceeded to put on soap crayon "makeup" **(C)**. This time she commanded me *not to watch*, threatening abandonment if I disobeyed. "If you look, I'm goin' out the door!" When I wondered if she would rather go out the door herself on her last day than have me tell her it was time to leave, she nodded and said: "I *know* this is the last day, and I'll cry, and I said I'll miss you and Dr. Mann. I'm gonna leave here, and I'm gonna drive my own car, and leave my mommy. *But I might lost myself.* Then I might walk at your place cryin', *'I lost myself!*'"

Lori then wondered if I might buy her play clothes for her birthday, and if we could exchange telephone numbers. She painted a huge, sloppy painting, and earnestly delivered her farewell address into the microphone of the small tape recorder we used for stories about

her art **(D)**. "Goodbye. I'm not gonna see you no more, but I'm gonna cry if I don't see you no more." I told Lori that I would miss seeing her too, and she went on: "Well, see, if I don't see you no more, I might cry. I wanna hear myself talk."

After listening to her speech on the tape recorder, a few faint smiles brightening her sad face, Lori said that we should kiss goodbye, and we did. She was thus able in her last session not only to express her anger, sadness, and sense of abandonment about the ending of her therapy, but also her affection and her growing autonomy.

Art Therapy Unblocks Grieving for a Little Boy: JEFF (6)

Since I, as a highly verbal adolescent and adult, was unable to find words or relief for my grief at the loss of Peter or my mother, it is no surprise that for a young child death is even harder to comprehend. The following story is about Jeff, a child I saw first for an individual art evaluation session, then in an art therapy group. The assessment revealed Jeff's profound confusion and tangled feelings about the loss of his brother who had died from a sudden cerebral hemorrhage. Both art and the presence of other youngsters allowed Jeff to begin to face the reality of what had happened and to explore his mixed-up feelings about it.

Six-year-old Jeff was referred for art therapy by his psychiatrist. Jeff's brother had died a year before, and although Jeff had been in treatment for many months, he had not yet been able to deal with his feelings about the loss. In his first art interview, Jeff painted "A Monster Head" **(E)**. Telling about the monster, Jeff expressed not only his awareness of his brother's death, but also his confusion about it.

"That's its hair. Know what happened to my brother? He died!" Then, about the monster: "He's gonna crush somebody up, maybe a snake. He'll go hiss … He'd blow poison dye right into the monster's face. Then they'll both die—then they're gonna fight in heaven with spears." When I asked how old the monster was, Jeff said he was six, and that he was named "Purvungi, the Happy Monster. But he cried and he's sad." When asked why, he said "'Cause his mother died. The people laid right on his mother. A big lightning bolt came down right into the cave and the mother monster got dead." Jeff's unresolved guilt about the disappearance of his rival, his identification with the dead brother who was one year older, and his fear of losing his mother, all came through eloquently in the story about his very first product.

After this initial diagnostic art interview, Jeff joined an art therapy group of children his age. One day, during snack time, the children were encouraged to make creatures out of marshmallows and toothpicks and to use them dramatically, like puppets. Jeff, whose brother's death had been caused by a cerebral hemorrhage, was able to express more openly some of his mixed feelings about the event, about which he had only giggled nervously in past group sessions. Stating that both of his marshmallow figures were boys, he put one down and said sadly, "His brother died … Then his father cried, and he felt sad, and he laughed." I wondered how it had happened, and Jeff said, "An accident … His mother was in the accident too, but she didn't die … His father said 'Don't die.'"

I asked if the brother died anyway. "Yeah, he died." Then I asked how the little boy felt, to which Jeff earnestly replied, "Sad, sad, sad … Yeah! I was sad when my brother died!" "I bet you were," I commented, after which Jeff went on with images he had until then been unable to verbalize. "Yeah. My brother died, and the veins in his head broke, and all the blood came out from his veins. But my brother didn't have an accident when he died. His veins just broke."

Art Therapy Releases a Worried Boy's Energy: ALAN (4 and 11)

This is the story of Alan, a child who came for art therapy first when he was 4 years old for three years of weekly sessions. Having found art therapy useful when he was younger, his

parents brought him back when he had a new bout of anxiety symptoms at age 11. Since he had enjoyed his first experience (one of the many reasons for art therapy's success with children), Alan was more than willing to come for another brief period of treatment.

Alan at Four Alan was a very tense little boy. Recently, he had begun to stutter and wet his bed. His parents, who had separated shortly before his symptoms appeared, were concerned about his increasing anxieties. During three years of weekly art therapy, Alan created dramatic disasters with blocks and clay figures, like tornadoes or earthquakes, knocking everything and everybody down. He also painted many volcanoes **(F)**. Over time, there were fewer and more manageable disruptions. By the time he decided to stop coming, he was a much more relaxed fellow.

Alan at Eleven Four years later, however, Alan began to have new versions of his old problems, something that often happens in the upheaval of puberty. While he no longer wet his bed and his speech was fluent, Alan was inhibited in other ways. Though strong, he would allow bullies to taunt him without fighting back. He had also lost interest in playing with other kids.

His parents asked if Alan and I could try working together again since it had helped when he was younger. At first he denied that he had any problems. But Alan also drew while he talked, mainly about how bored he was in school. The drawings offered clues to his inhibitions. After a few weeks of architectural designs, he began to describe and draw his plans for torture chambers **(G)**, an interest he had when he was younger, too.

At this point Alan was able to tell me about intrusive thoughts of awful things happening to his father, his mother, or both. My understanding was that he was once again having problems with his anger at his loving but busy parents. After several months of weekly sessions, Alan seemed more comfortable with his anger, but still wanted a way to counter his "bad thoughts." So I told him about some cognitive-behavioral methods, using techniques like "thought stopping," and he figured out a few of his own.

Moreover, Alan's complaints about school were legitimate. A creative boy, he was stifled in his conservative school, so I suggested that he and his parents explore other options. They finally settled on another place, where Alan's artistry was valued, and he began to enjoy school again. He even made so many friends that he asked to be allowed to stay for the "After School Program," and we were able to say goodbye.

Alan's aggression was something he was frightened of and against which he defended himself, creating symptoms like enuresis and obsessional thoughts. Jack, who was older than Alan when he began art therapy, had been a "difficult" child since he was very young, exasperating his parents and teachers with his oppositional behavior. However, when he developed panic attacks in addition, his frightened family brought a very resistant boy for art therapy.

Art Therapy Allows an Anxious Boy to Feel Secure: JACK (12)

Although Jack had always had problems in school, his parents had resisted the teachers' suggestion that it might help him to see a therapist, thinking that he would outgrow it and not wanting anything to be "wrong" with their beloved only son. Nevertheless, when as a preadolescent he suffered a series of panic attacks, they became worried and decided to consult a clinician, to see if therapy might help. Jack himself was extremely negative about seeing a "shrink," keeping his sessions a secret from his friends and even from

Figure 1.9 A clay creature's head by Jack.

his sister. Like many, he was afraid that he would discover that he really *was* defective, maybe even "crazy."

In our first meeting, he acknowledged that he had only come because his parents had insisted, and told me that he was to get a reward. At first, Jack demonstrated how well he could draw some of the cartoon characters he had invented **(H)**. He then began to work with clay, and created a series of increasingly massive and expressive heads. Initially the heads were fairly human, but soon began to look more like dinosaurs **(I)**, with extensions of various sorts, including teeth, tongues, spikes, and horns **(Figure 1.9)**. Jack was proud of his sculptures, displaying them on a large table in my office, where they could be admired.

Jack talked constantly while he worked about the "pressure" he felt to perform in sports and scholastics at the competitive private school he attended. Although he was competent in both, he vacillated between bragging and worrying. As he became more trusting, he began to disclose more about his feelings and anxieties, sometimes seriously, sometimes playfully. Over time, I grew to understand Jack's deep fears of inadequacy, of injury, and of his own helplessness—fears he usually masked with an air of bravado.

Occasionally his terror would break through at home, and he would have another panic attack. Sometimes he would regress and have a tantrum, scaring himself and his family. Jack was masterful at manipulating his parents, promising to do what they wanted if they would buy him one of the many objects he desired. Periodically, his parents would request a meeting to "touch base," sometimes because he was being oppositional in a passive-aggressive fashion. His verbal attacks on family members increased for a time—a common side effect when therapy uncovers repressed hostility. Although Jack had been oppositional all his young life, he was not in touch with the depth of his rage toward his loving but sometimes overly involved parents.

With Jack's permission, I sometimes showed his folks his artwork, which often "explained" him better than my words. The meetings helped me to monitor the effects of the therapy, since his parents could tell me more clearly than Jack what was going on at home and in school. Our sessions also helped them to understand Jack's puzzling behavior, so that they could set limits as well as empathize with him.

As he began to get more comfortable with, and less frightened of, his hostile and competitive impulses, Jack's performance anxiety lessened. His artwork changed too.

He began a series of acrylic paintings, in which he explored similar themes, but with more disguise. He received as much attention for these sublimated expressions of his concerns as he had for his sculptures.

He was able to say goodbye after two years, as he entered adolescence. Without clay or a brush in his hands, I doubt that Jack would have been able to tolerate psychotherapy, despite his verbal fluency. With art, he was able to master his anxieties almost painlessly.

Betty Jane, the subject of the next story, was well into adolescence and as articulate as Jack. Like him, she was brought to therapy by her mother and was extremely resistant at first. Like Jack, she too was able to work comfortably thanks to her interest in art.

Art Therapy Helps a Talented Teenager: BETTY JANE (14)

Betty Jane's parents had just announced that they were going to split up, her older sister had just left for college, and Betty Jane was becoming more and more depressed.

She was also skeptical about therapy, since there was no way treatment could change the reality with which she had to cope. Her mother, however, asked her to come for one interview, and she agreed to my suggestion that she try a few sessions of art therapy and then decide if she wanted to continue.

A talented artist, Betty Jane enjoyed exploring different media. Although her art was more attractive than it was revealing **(J)**, the pictures and her answers to my questions about them gave me clues to feelings she was not yet conscious of **(K)**. Betty Jane continued to be ambivalent about our weekly meetings, especially disliking the ones where she would break down and cry or reveal something she later regretted. Nevertheless, she came reluctantly for several months, using her sessions mainly to express her distress about all the changes in her life.

Two years later, Betty Jane called, saying that although she was "awfully busy" with plays and exams and activities, she'd like to come in again to work on some issues related to her final year of high school. Within a few sessions, drawing as she spoke, Betty Jane told me about some frightening dissociative episodes, when she had felt as if she were observing herself—like "out of body" experiences. While she hadn't said so, I wondered if she was worried that she had inherited the mental illness in her mother's family, so I suggested a diagnostic evaluation.

Happily, both psychological and neurological testing revealed that the cause of her spacey moments was anxiety and not biology. She was able once again to concentrate on her studies, and to win a scholarship to a prestigious art school. Betty Jane was also able to say goodbye to her parents, no longer worried about whether they could manage without her.

And this young woman—so skeptical about the value of therapy when we began, challenging me to show her how it could possibly help—asked if I knew a therapist in the city where she was going to college, "just in case." After her first semester, she reported with relief that being among other artists she discovered that everyone there was like her, and she no longer felt "weird"—like the Ugly Duckling when he found the swans.

Art & Drama Therapy Liberate a Depressed Adolescent: JIM (17)

Jim, often depressed, had a hard time expressing himself in the group **(L)**. His first drawings were of heroes, but they were usually incomplete **(Figure 1.10)**. Almost all of the powerful athletes were missing parts of their bodies—sometimes an arm, sometimes a leg—and were often subtly cut off by the edge of the paper. For many sessions, he worked on an elaborate

Figure 1.10 An early athlete by Jim.

picture of superheroes, like the Green Lantern and the Green Arrow, perhaps triggered by his feelings of vulnerability in the group. This same sense of helplessness seemed evident in his spontaneous dramatizations; no matter how his role began, he almost always ended up as a victim, hurt and injured **(M)**.

As a dental patient, for example, Jim was so passive and wobbly that he kept tumbling to the floor, as though—like a baby—he could not sit up without support. He had actually begun as the dentist in that drama, but was unable to maintain the assertive role and soon switched to the weak patient, who finally had to be tied in the chair to keep him from falling on the floor.

In the same way, he volunteered to be a tough cop, driving his police car, when all of a sudden he changed the script, and was hurt and injured in an accident. Rescued by a doctor, he seemed to enjoy the idea of being a passive patient, even when put on the table for an operation. Without a whimper, he masochistically submitted to the doctor's primitive brand of anesthesia—a bop on the head with a wooden spoon.

In a later drama, he played a boss who was able to give orders and to be a big shot with his secretary, but could not confront the angry male employee he was supposed to fire, cowering and able to gesture assertively only *after* the man left the room.

As he was taking these first tentative steps to express anger in dramas, however, his drawings began to change. More often, the athletes were complete figures, with few, if any body parts missing **(Figure 1.11)**. Trying other media, he made a tall (phallic) three-dimensional plastic construction, and later a huge sword and a clay dagger.

One day he playfully pretended to be superpowerful and slowly lifted up a "heavy" chair, said to weigh "at least fifty thousand pounds." Becoming more comfortable with this aggression, Jim played the role of a domineering husband, bossing his wife around. He demanded special food, insisting that she slavishly follow his commands, and indeed was quite authoritarian **(N)**.

Figure 1.11 A later athlete by Jim.

Having learned to express his aggression outward instead of inward, he experimented with many roles, sometimes using a toy gun to attack or protect himself from his enemies. Full of courage, one day Jim challenged the male leader to a mock pantomime battle. When Dr. Borrero showed him how to fight in slow motion, he was able to exert the necessary control, yet still win the contest. He kept coming back for more, repeating his slow-motion, in-the-air knockouts, thus mastering the anxiety about the once-feared effects of his own aggression. And, equally important, he was able to sit down and talk with the leader about the experience when it was over.

In one improvisation, Jim started to frantically gobble up bunches of French fries, saying that they were thermometers and would make him strong. Drs. Irwin and Borrero became MDs who tried to figure out the best course of treatment for such a fantasy, drawing X-rays that showed the thermometers, and measuring him with a yardstick to confirm that he was growing stronger. It was probably helpful to Jim that the leaders were able to join into the spirit of his zany drama, and to use their own creative resourcefulness to help him deal with his wild fantasies.

Through the leaders and the other group members, Jim was able to grow in remarkable ways. When I ran into him in the airport 20 years later, he greeted me warmly and was proud to tell me about his personal and professional success.

Art Therapy with a Depressed Woman: MRS. LORD (27)

Mrs. Lord and her daughter Lori, described earlier, each saw a psychiatrist and myself every week, as described in "Previews of Coming Attractions." Dr. Mann had requested art therapy primarily for Mrs. Lord, who was so well defended that it was hard to get past her glib rationalizations in verbal psychotherapy.

Figure 1.12 Mrs. Lord looks at her painting.

Although she had come to the clinic because her formerly cheerful daughter Lori was sad, Mrs. Lord was also depressed. Both were reacting to Mr. Lord's recent announcement that he wanted a separation, and his subsequent move out of their home. Lori cried a lot, but Mrs. Lord was able to hide her sadness behind a cheerful façade.

From the beginning, however, this young woman was able to tell herself things in art that she was not yet ready to put into words, evident in her very first session, which is described and analyzed in Chapter 1 of *Approaches to Art Therapy* (Rubin, 2001), as is her penultimate session. After becoming comfortable in art therapy, Mrs. Lord usually began a session by telling me what was going on in her life while painting or drawing **(O)**. Then we would look at what she had made on the easel **(Figure 1.12)**, which allowed her to feel less self-conscious than if she had to make eye contact with me, one of the reasons art therapy is effective **(P)**. Mrs. Lord quickly learned to associate freely to her images, saying whatever came to mind as she looked at her pictures. After she had reflected on her verbal associations, we would attempt together to figure out their relevance to her life.

Five Months Later: A Speechless Session One day Mrs. Lord arrived looking uncharacteristically somber. She said she had almost not come, and was so upset that she wondered if she would be able to talk about anything at all. I asked if she could draw her feelings rather than trying to put them into words. Mrs. Lord quickly selected a piece of black construction paper (12" x 18") and large poster chalks, by then her favorite medium. She furiously scribbled a series of color masses whose brightness screamed out against the black—red, yellow, orange, magenta, and white. She then grabbed another piece of black paper, and quickly drew a series of multicolored lines that met, but did not intersect.

Putting both on the easel, Mrs. Lord reflected on what she had made. She entitled the first drawing "Shock" **(Q)**, and then, much to her embarrassment, this usually well-controlled woman began to sob. "All I have to do is break down and start crying," she said, "and everyone will think I am crazy! … He's the one who should be here!"

She then said she had just discovered that her husband had a girlfriend, and that the affair had been going on for quite a while. Still agitated and tearful, Mrs. Lord went on to say how painful this shock had been. The title for the second picture was less clear to her than the first. She groped for words, finally settling on: "Ambivalence, Dilemma, Uncertainty, and Confusion" **(R)**. She was unable to say much more, except that the image described her tangled emotions. By the end of the session, Mrs. Lord had regained her composure. While still visibly sad, she was no longer as tense as when she arrived.

The art activity allowed Mrs. Lord to release some of the feelings that were flooding her. The drawings, which expressed her anguish and confusion better than any words, also helped her to sort out just what was happening, both internally and externally. She was then able to begin to consider how she might cope with the unwelcome news. In other words, articulating her inner world helped her cope with the outer one.

Charting Her Course in Charcoal At the following session, it seemed appropriate midway through to suggest a theme to Mrs. Lord, one which grew out of her own drawings and verbalizations. Still reacting to her discovery of the preceding week, she entered looking tired, saying "I'm not too full of ideas this week." While working with charcoal, a new medium for her, she was unusually quiet and absorbed, and chose to view the first three drawings together after their successive execution.

The first was identified as "A Tree Alone on a Cloudy, Dreary, Rainy Day." She said there was probably a storm brewing, that the weather was going to stay dark and worsen, and that the storm would be severe. Then, as if uneasy, she said, "Really, I don't feel gloomy. Everything depends on me. I've got the ball." Looking at her second picture she said it represented "Interwoven Feelings or Mixed Emotions" stimulated by recent events.

Viewing the third picture she said quite spontaneously, "Mickey, Lori, Tim, and Me" (the family). The top shape was seen as Tim, her husband, with an arrow pointing to the other three. "If he could only be honest," she said. "Everything depends on him. If those who depend on him could have faith and trust in him, everything would be better. He feels he has to lie. At times, he won't tell things that could help and when you find out, it's up to you to ask."

She then related in detail her recent discovery that he had a girlfriend, giving a thumbnail description of subsequent events. Referring to the discovery, she said, "I would rather not know. But that might not be good. But I do prefer to be naïve," an attitude she acknowledged as characteristic.

Mrs. Lord seemed unsure of what to do next. Since she was so ambivalent about confronting her present reality, I suggested that she try to portray the current situation in a picture. She drew a scale with black oval masses on either side, saying, "He has to weigh which is more important and which will give him more happiness. I think he's torn between the two, and he doesn't know which he wants now" **(Figure 1.13)**.

On the right side of the scale she identified herself, the children, and Tim; but as she said this, she crossed him out, saying she really wasn't sure she wanted him there. On the left, she said, is "Tim and his Freedom." Realizing that she had "accidentally" placed him with the family, she restated, "I'm not even sure I'd *want* him here. It's important for him to admit where he belongs." She made no mention of the obvious size differential on the two sides of the scale and, when it was pointed out, seemed uncomfortable at the realization.

Her next drawing was done rapidly, and was described as "Tim and his Family" on the bottom level, and "Tim and all the Girls who Find him Attractive" on the top half. Tim is represented by the tallest line in both sections. She commented that even before the

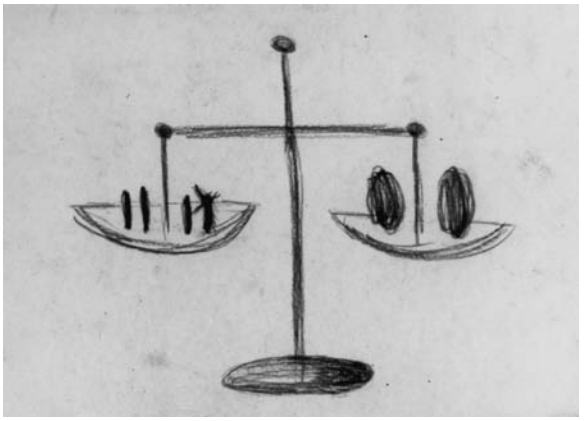

Figure 1.13 Mrs. Lord's scale: Family vs. girlfriend.

separation, he had always seemed to prefer going out to "being at home with the family, which was like being in jail."

Asked if she herself ever felt that way, she replied, "I'm beginning to wonder if *I* wasn't the one who was missing out!" Suddenly aware of her statement, she quickly said that of course she liked being at home with her children, and did not like going out as much as Tim. She concluded that she did not see how anything she could provide at home with the children could ever really compete with what he could find outside.

Despite a defensive idealization of me as a "good mother," Mrs. Lord was able to use weekly art therapy to explore her feelings of rage and hurt toward both her parents and her husband, and to accept her ambivalence toward her children. She became able to use her artwork as a valuable source of information about herself. Although saying goodbye was hard, she coped in part by taking an art class after termination of the 7-month treatment.

Art Draws out Despair in Marital Therapy: MR. & MRS. T.

I once worked with a couple for two years in weekly therapy, at first regarding their blind, multiply disabled daughter who was being seen by a child psychiatrist. We had used art during an initial family evaluation and in some of the diagnostic interviews. While not the main mode of communication for this concerned couple, it was especially useful in dealing with the most loaded and difficult areas of their relationship, which eventually emerged as significant factors in the girl's problems.

During one session, after much veiled expression of resentment from both about disappointment in the partner, I wondered if they could draw each other, working on opposite sides of an easel. These images actually became reference points for the remainder of the treatment. Mr. T. represented his wife as "The Rock of Gibraltar" **(Figure 1.14)**, a tower of strength and stability in the shifting currents of life (**S**). At first he said that was how she *really* was. Then, responding to her hurt and anger at such unrealistic expectations, he acknowledged that he wished she would never show vulnerability or weakness, but that he had often been let down.

Meanwhile Mrs. T. was in tears about how impossible it was to please her husband, how hard it was to get his sympathy and concern when she herself was needy, and how deprived and lonely she felt. She represented him as "Always Busy" **(Figure 1.15)**, all wrapped up in his own activities, with no time left for his family—playing his guitar and daydreaming

Figure 1.14 "The Rock of Gibraltar." Mr. T's Image of Mrs. T.

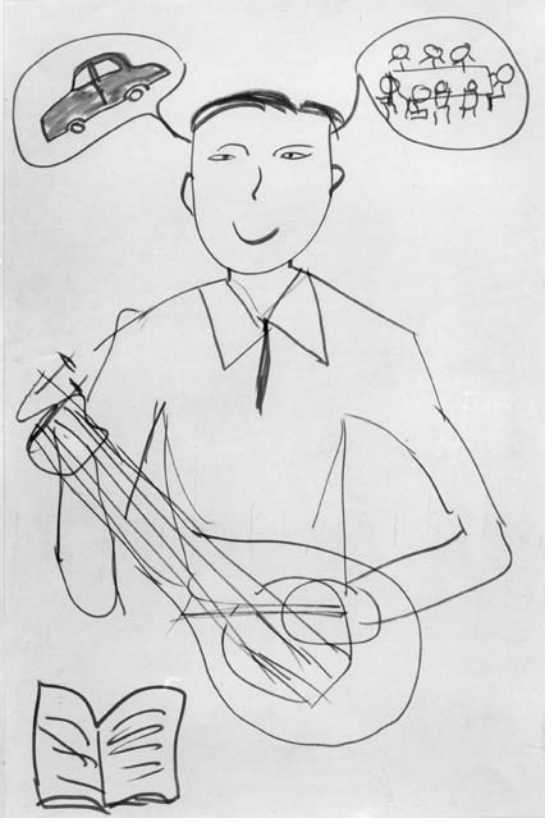

Figure 1.15 "Always Busy." Mrs. T's Image of Mr. T.

Figure 1.16 Two adults drawing together without talking.

about his interests, none involving her or the children (**T**). While at first defensive, Mr. T. finally agreed that she had a point, and remembered how he had placed himself far away from the others in his family drawing a year earlier.

Six months later, a good deal of work was accomplished by drawing together without talking during a number of sessions. In such a process, communication issues can be experienced and discussed in an affectively charged manner **(Figure 1.16)**. Since both Mr. and Mrs. T. tended to intellectualize often and did it well, art was extremely useful for getting in touch with their feelings.

Art and Writing Help in Adjusting to a Painful Reality: MARJORIE (45)

Even when one is helpless to change a painful reality, art can still help in the healing of a wounded soul, as in the following story about a woman with whom I worked and who taught me a great deal. Marjorie was grappling with the loss of the unrealized potential of her gifted son, recently hospitalized after a severe mental breakdown. Her handsome, brilliant boy had been forced to drop out of college, move back home, and was struggling to function. She feared he might be permanently crippled by the invisible damage of mental illness. A normally optimistic and competent woman, Marjorie was coping with the loss of hope, and much of the time, the loss of her usual power to help.

She was reluctant to waste her valuable treatment time doing art, and had a pressing need to talk about her pain. She wrote in a journal between her sessions too, mainly to deal with her internal anguish. But Marjorie was curious about art therapy, and wanted to try it out. So she began to experiment with materials at home, following my advice to "just fool around" with a medium and get to know it. After trying several media, she found one she preferred, and began to spend more and more of her spare time using it, surprised and delighted by how rewarding it was. Creating art took on a life of its own, and became a valued fringe benefit of her psychotherapy.

Marjorie was eager to share her artwork with me, but was equally resistant to looking at her creative products with anything but an aesthetic eye. Analyzing was quickly dismissed as intrusive and possibly destructive. I was surprised at my own willingness to respect her wishes, and would have expected more inner regret. But in truth, her art developed so nicely and organically as she found not only her voice (the medium), but also her language (the style), that I didn't want to interfere in that process, for it had its own integrity and therapeutic benefit.

Her verbal therapy went well, allowing me to leave the art untouched by verbal analysis with no sense of frustration. Most intriguing was that her tremendous pain, of which she spoke and wrote eloquently, was not visible in the artwork. Marjorie explained it by referring to Suzanne Langer (1953), a philosopher whose work appealed to me long before I was a therapist. Langer's notion was that art is essentially "forms of human feeling"—not specific emotions, but a deeper emotional substrate.

Perhaps when someone is grappling with helplessness in the face of a human tragedy, they need to get in touch with deeper forces in order to find some peace, to come to terms with an awful reality. Marjorie's artistic creations, in addition to being highly original and beautiful, had a sense of harmony, of peace, of the quiet that finally follows even a raging storm. So for this woman, art became an unexpected by-product of her therapy, something she was able to keep and continue to develop as her own.

In Her Own Words Marjorie wrote between her sessions, mostly to manage her pain. Sometimes she wrote about the art and her therapy. Here are a few excerpts, so you can hear what creating came to mean for her.

"The Art" (written after 8 months of therapy)

- From the beginning—a surprisingly sure sense of what I wanted to do and how I wanted to do it (in the absence of any knowledge of media or technique).
- *An oasis, the process enough in the first few weeks.*
- Probably the strongest feeling, initially and throughout, about identity: how quickly I found my voice, recognized what was mine, discarded what was not …
- Not much investment in the judgment of others, no real concern. The art has really been for me, not even for Judy.
- Pleasure and satisfaction at the acceptance, a sense of being an artist …
- Throughout, experiencing the art as a gift, wanting to return it to Judy, making sure that there are always "extras," disappointed when I have only one of something I like.

The Different Functions of the Writing and the Art …

- The writing serving to clarify, express, contain, communicate; a vessel for the articulation of the pain. The art feeling very different, seeming to be primarily expressive, from a different part of the internal landscape, enhancing the strong and healthy components, communicating only in the sense that those areas have become more accessible to Judy as well as to me, no small accomplishment.
- Explaining why I have held onto the art, because it is healthy and satisfying and diverting, all of which have been important. At a time when I needed to feel healthy, needed to be diverted …
- And as quickly and easily as all of the above has flowed when I began writing about the art, the analysis is removed from the experience. Really a simple decision to

continue with something that felt right and constructive, allowing it to unfold in its own way and its own time."

Seven Months Later, She Wrote … Speaking of filling up the time, the art has to be watched. It has been so satisfying, is so "safe," that it can be counterproductive. There is a genuine desire to share what has been happening with Judy, my sense of excitement and pleasure. Certainly an unexpected consequence, that the art would emerge and develop in this way, take on a life of its own. Assuming it must be satisfying for Judy too, to have opened such a door under these circumstances, to see the art unfold and flourish. A very small artistic territory, but one that seems to be teeming with activity and satisfaction for me.

And Then, Three Months Later, More on the Art …

- Rereading what I wrote earlier about the art, glad that I captured the experience then. Because it has been evolving, feels different now.
- Feeling then that it was art rather than art therapy, certainly true on the surface. But recognizing now that it has also been art therapy, on many levels. Most important has been the sense of the "art as prototype," that it has symbolized much that is important about me, in therapy as in life.
- The sense that I needed to "deliver" in some fashion with the art, the need deriving both from my increasing commitment to therapy and from my recognition that this was Judy's domain, an important part of her life, so that non-delivery would have been very troubling, that possibility undoubtedly producing some of the energy that has fueled the art from the beginning. A sense that I needed to make it "work," to meet both of our needs … And if I had to do it my way, I had to do it well, so that our mutual needs could be met.
- Of course, just as it has been with my mother, with my adolescent struggle for identity. I had to forge out my own path, during a turbulent adolescence. The struggle was worthwhile, ultimately meeting both of our needs, Judy having served as midwife to the creative offspring, having had the opportunity to watch it develop, at least in its infancy. A scenario out of an analytic case study, so I have delivered on that level too …
- A much stronger proprietary sense now, of "my things," instantly recognizable as they emerge … the continuing recognition of the small artistic territory that I inhabit, but also a sense of its sufficient expandability, that it will be as large as it needs to be, as I explore my personal artistic landscape.

And During the Termination Phase … As I write about the art, for probably the last time in therapy, feeling the connection with termination. A sense of impending loss, an empty space, where the therapeutic alliance has been. And the art a bridge … And now with Judy, taking the art with me as I prepare to depart, leaving the writing in case it can be of use. Feeling enormously thankful for the therapy, for the art, both having enriched my life in unexpected ways …

It has been a fascinating and satisfying artistic journey for me, at a time when my journey in life was filled with pain and turmoil. As Judy has been the midwife for the artistic process for me, I seem to have served as the midwife for the art. Because it really has seemed to have a life of its own from the beginning, needing room to emerge and define itself, to unfold and evolve, resisting my efforts to intervene and transform. The process has seemed much like

my life (thinking of my adolescence), trusting my intuitions, willing to explore uncharted territory, an inherent sense of direction and goodness (or poorness) of fit as things emerged. The process similar in life and in therapy and in art …

Because Marjorie was a very bright woman, she was able to get past her initial distrust of psychoanalytic therapy, and to enjoy the transference learning available in the process. The art, initiated to please as she suggests, became an unexpected by-product of her therapy, an oasis, something she was able to keep as her own, along with the adjustment she accomplished through hard work. I am grateful for the learning she provided for me, and for her willingness to teach others through letting me share her written reflections. Although she preferred that I not show her artwork, the reader should know that it was not only uniquely her own, but also truly beautiful.

Preview of Coming Chapters

Now that you have gotten a peek at the process of art therapy, you will want to find out more about it. In Chapter 2, you will learn how art therapy is similar to and different from related fields. Chapter 3 tells the story of its development as a profession. The "*basics*" of doing art therapy, including treatment planning and evaluation, are outlined in Chapter 4, which also notes some of the reasons why art therapy works. Art therapy is conducted using many different theoretical *approaches*, which are noted in Chapter 5.

The use of art in *assessment* is described in Chapter 6, and some of the technique(s) used in treatment in Chapter 7. Since art therapy can be used with people of all ages, Chapter 8 deals with some of the issues and developments in work with children, adolescents, adults, and the elderly. Chapter 9 focuses on some of the most common groups of people and problems art therapists work with, such as those with disabilities and eating disorders. Art therapy is also used in many different kinds of settings and for a broad range of purposes, some of which are noted in Chapter 10.

Chapter 11 deals with professional issues, such as education, standards, ethics, and public information. Chapter 12 is about the future, offering suggestions for further study, as well as an overview of current trends. Throughout, the text is illustrated with the images on the pages, as well as with the images and video clips on the **DVD**, a list of which is found on the **DVD** itself. The book ends with a list of resources (professional associations, journals, conference proceedings) and references (books on art therapy and related areas, which are referred to in the text).

CHAPTER 2

What Is Art Therapy?

Anything that is to be called art therapy must genuinely partake of both art and therapy.

Elinor Ulman

Art + Therapy = ?

In one of the first issues of the *Bulletin of Art Therapy*, when the field had only recently been born and named, editor Elinor Ulman **(Figure 2.1)** wrote about how hard it was to classify this new discipline, with its roots and branches in so many areas. Ulman concluded simply and clearly that art therapy needed to be true to both art and therapy. She defined therapy as "procedures designed to assist favorable changes in personality or in living that will outlast the session itself." And she defined art as "a means to discover both the self and the world, and to establish a relation between the two."[1] She also called art "the meeting ground of the inner and outer world."[2] Her statement on their relationship was clear: "the realm of art therapy should be so charted as to accommodate endeavors where neither the term art nor therapy is stretched so far as to have no real meaning."[1]

Despite Ulman's early and inclusive definition of the newborn profession, there were a series of what might be characterized as rather impassioned *custody battles*. The biggest source of tension—still evident in varying forms—was whether *art* or *therapy* would be designated the dominant parent. Those who felt that art therapy's primary contribution was in the healing power of the creative process were drawn to what came to be called "art *as* therapy." Those who felt that art therapy's primary value was as a means of symbolic communication sometimes called it "art *psycho*therapy." If you peruse the literature you will notice that, while most refer to the field as "art therapy," some call their work by other names, such as "expressive analysis," "clinical art therapy," "psycho-aesthetics," or "expressive therapy."

Figure 2.1 Elinor Ulman, founder, *Bulletin of Art Therapy.*

Art Therapy: What It *Is* and What It Is *Not* (DVD 2.1)

Art therapy is a unique profession, with the entry level for practitioners only after two years of full time training at the master's level. This is necessary because doing art therapy in the fullest sense requires combining a deep understanding of art and the creative process with an equally sophisticated understanding of psychology and psychotherapy.

In the years since the first edition of this book was published, an awareness of "art therapy" as an idea has become part of our culture. This heightened consciousness of the healing power of art has also bred confusion. It seems, therefore, even more imperative today to clarify the distinctions between trained art therapists and others providing therapeutic art activities. This list includes artists-in-residence, art teachers, and volunteers who provide therapeutic art activities to individuals under stress, from homeless shelters to hospitals.

This list also includes psychologists, social workers, counselors, and psychiatrists who request drawings or incorporate creative tasks in their clinical practice. All of these individuals are involved in significant and necessary work, whether their impact is on individual patients and families, or on groups in the community. However, when they provide art activities for those they serve, it is similar to but different from the work of credentialed professional art therapists. On the **DVD** you can see a psychiatrist asking a child to draw **(A)**.

Since art therapy overlaps so many other areas, a useful way to define it is to compare and contrast it with closely related disciplines and groups. Despite the fact that art therapy is better known today than ever before, it remains poorly defined and misunderstood by many (**B**). Even when people have heard of art therapy, they are often unclear about just what it is. Art therapists contribute to this confusion, for they have different backgrounds and ways of describing what they do. So it is essential to know not only what art therapy *is,* but also what it is *not*.

Many people think, for example, that art therapy means working in art with those who are different from the norm. But the definition of art therapy does not depend on *who* is being seen, any more than it is a function of *where* the work occurs; rather what is important

is *why* it is being offered. When art materials are given to disabled or troubled individuals, the activities may well be educational or recreational. When providing art for the purpose of constructively filling leisure time, that is not art therapy. Even in a psychiatric setting, if the primary purpose of the activity is learning skills or having a pleasurable experience, it is certainly *therapeutic*, but it is not art therapy.

The essence of art therapy is—as Ulman said—that it must be true to both parts of its name—art and therapy. The primary *goal* of the art activity, therefore, must be *therapy*. This usually includes assessment as well as treatment, for any therapist needs to understand who and what they are treating. An art therapist also needs to know a great deal about the wide range of ways in which art can aid in understanding, as well as in helping people to grow and to change.

The field of psychotherapy is complex, encompassing many different ways of understanding human beings. It also includes many different ways of helping people to overcome difficulties in development or adjustment. In order to offer art as *therapy*, it is essential to be trained as a *clinician*. Even the most sensitive artist or teacher is *not* a therapist, no matter who the student happens to be or where the teaching takes place.

Just as it takes years of study and discipline to master the visual arts, so it takes time to master psychology and psychotherapy. Like related disciplines, such as counseling and clinical social work, the master's degree is the entry level for practice. As with all forms of therapy, understanding and synthesis in art therapy come only with experience. To integrate knowledge about art and therapy requires two years of graduate study, which includes not only coursework, but also extensive clinical training, with many hours of supervised work with patients **(Figure 2.2)**. Students are required to have a minimum of 700 hours during training and 1500 post-master's hours in order to be credentialed as a Registered Art Therapist (ATR). To become a Board Certified Registered Art Therapist (ATR-BC) requires passing a rigorous written examination.

Figure 2.2 Bruce Moon supervising an art therapy student.

Figure 2.3 Viktor Lowenfeld, therapeutic art educator.

As in any work that touches people's lives, often when they are most vulnerable, learning to be a better art therapist is a lifelong task, one that cannot be mastered without continuing education, ongoing guidance, and constant self-inquiry.

Art Therapy and Art Education (DVD 2.2)

There is naturally an element of education involved in art therapy, because the work includes helping others to create. But teaching is secondary to the primary aim, which is therapy. In other words, if an art therapist teaches techniques, it is not for the sake of the skill itself, but rather in order to help the person to achieve, for example, a more articulate expression of a feeling, a higher level of sublimation, or an enhanced sense of self-esteem. On the **DVD** you can see Edith Kramer teaching color mixing **(A).**

Similarly, there are therapeutic aspects of art education **(Figure 2.3)**. The very best art teachers are growth-enhancing individuals, who nurture a student's feeling of competence in a broadly beneficial fashion. And there is no question that art activities can be conducted so as to promote social and emotional growth. Art is intrinsically healing for many reasons, such as: discharging tension, experiencing freedom with discipline, representing forbidden thoughts and feelings, visualizing the invisible, and expressing ideas that are hard or impossible to put into words. On the **DVD** you can watch a teacher working on color mixing with children in order to deal with identity issues **(B)**.

Invisible Differences

One reason why it is so important to distinguish among art for different goals is that the art activities themselves may not appear different to an untrained observer. An individual art therapy session can look like an art lesson, and an art therapy group may appear to be a class, like the one on the **DVD** from a psychiatric hospital **(C)**. The materials are the same, and approaches in both art therapy and art education range from open-ended to highly structured. Even the words of the therapist may be indistinguishable from those a friendly teacher might use. The primary distinctions are *invisible*—inside the mind of the art therapist and of the participant(s).

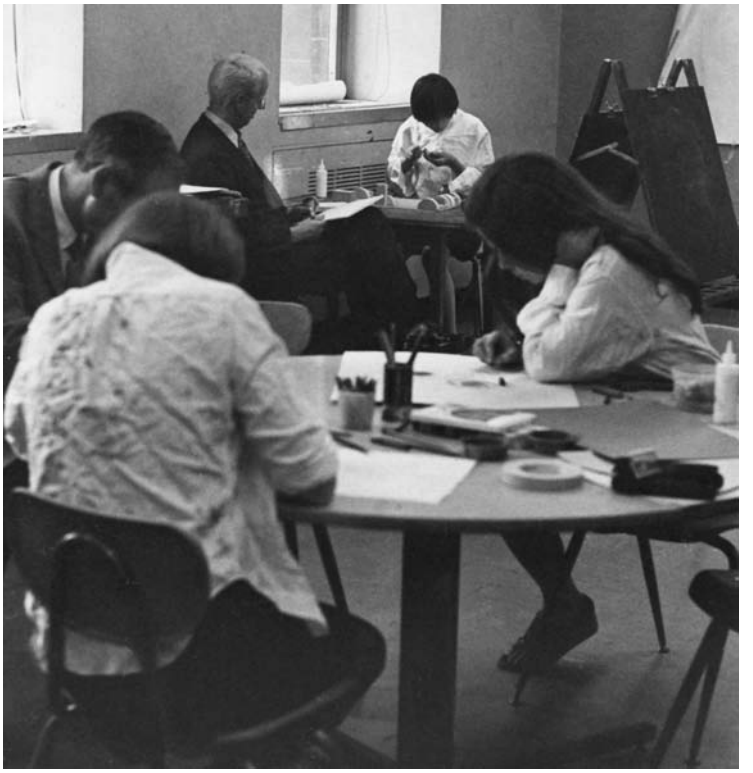

Figure 2.4 Family members creating individually.

When an art therapist conducts an *assessment*, for example, she is looking with a clinically trained eye and listening with a psychologically attuned ear to what is happening. She is attentive to all aspects of behavior, hoping to understand as much as she can through the individual's interaction with her, with the art materials, and in response to whatever task(s) have been presented. From these clues, she does her best to assess where he is developmentally, what his primary conflicts are, and how he is coping with them. On the **DVD** are some excerpts from an art evaluation with a teenager **(D)**.

Similarly, when an art therapist works with a family, she is interested in what their art and behavior can tell her about both individual and interpersonal dynamics. She looks at how they relate to one another, which helps her to understand the problems of the "identified patient" and of the "family system." Anyone observing a *family art evaluation* would see an exercise in which parents and children make things individually **(Figure 2.4)** and jointly **(Figure 2.5)**, and then talk about their artwork, as in the excerpt on the **DVD** (**E**).

If the family is relaxed, it might look like a pleasant recreational activity. The art therapist's interest, however, is in understanding family dynamics—through the symbolism of their art, in the context of their behavior. Similarly, *group art therapy* might look like an art *class*, but learning about art is secondary to learning about the self in relation to other people.

Participants "Know" the Difference

Eventually, the individuals involved in art therapy themselves become aware that this is a different kind of art experience, even when its therapeutic nature has not been made explicit.

Figure 2.5 Family members jointly creating a mural.

While it is customary to explain to those who can understand the purpose of the art activity, that is not always possible. But even the very young and those with language problems soon grasp the special nature of art in therapy.

I was reminded of this by the response of some children I saw in a pilot program at a school for the deaf, like the boy on the **DVD (F)**. When some of the teachers asked to observe the art sessions, the children declined, perhaps needing to keep their often-angry and confused imagery private. Similarly, a teenager signed out the window to his friend that he was with "an art lady who helped him with his problems," although we had never discussed the purpose of his visits or called them "art therapy."

The same thing occurred with a group for women fighting substance abuse that a drama therapy colleague and I conducted at the Pittsburgh Center for the Arts. Even though all of the participants were in a residential treatment program for substance abuse, coming to the center was explained to them by their social worker as an opportunity to be creative in a class. She feared that they would be resistant to art and drama *therapy*, because of the intensive individual and group counseling in which they were required to participate as part of their recovery program.

Nonetheless, from the beginning of the twelve-week group, the women used the sessions to create images related to their concerns, talked about them freely, and often said how therapeutic they found the experience. Frequently they took what they had created in the group back to the residential setting in which they lived, so they could explore issues in the artwork further with their individual therapists **(Figure 2.6)**. Their openness and awareness is evident in the brief clip on the **DVD (G)**.

So there *is* a difference between art for pleasure and art in therapy, but it is not always visible or easy to explain. Of course, there are times in art classes when the activity is therapeutic, whether at the level of release or of reflection. Similarly, there are times when what goes on in art therapy is mainly educational or recreational, where learning or pleasure is the focus for the moment. But the differences in the primary goals remain, for both teachers and therapists.

Figure 2.6 A mask from an art/drama therapy group.

Art Therapy and Art for People with Disabilities (DVD 2.3)

Educational and Recreational Settings

The distinctions between art therapy and art education are especially likely to be blurred in the area of art with the disabled. Two professionals with a foot in each field once diagnosed both disciplines as suffering from *"a shared identity crisis."* The crisis was a territorial one: Who was the best kind of person to offer art activities to people with disabilities? On the **DVD** you can see a program led by an art teacher I supervised at an institution for children with physical disabilities (**A)** and an art therapist helping a deaf child at a school in Kansas **(B)**.

Although the kind of art therapy provided to disabled individuals often has a psychoeducational orientation, the two are overlapping but not identical. There is not only room, there is also a need for both teaching and therapy through art with this group. For example, when I visited the Jewish Guild for the Blind in New York City in 1969, Yasha Lisenco (1971) taught art and Edith Kramer (1958, 1971) did art therapy—with similar sensitivity, but different goals.

While there will always be more teachers in schools and more therapists in clinics, it would be foolish to assume that the optimal division of labor would be in terms of *where* the work is done or *who* is being served. As noted earlier, *what* is done may look very similar, but *why* is the critical variable. When the need, for example, is for psychological understanding, a therapist is the art giver of choice. Only a trained clinician knows how to use art for assessment, or to identify the conflicts causing symptoms. When the goals of a given art intervention are social or emotional, a therapist—who understands interpersonal and intrapsychic dynamics—is equipped for the job in more ways than an art teacher.

Art therapists are trained to assess and to treat those problems that interfere with people being able to benefit from education—including learning art. Because of their clinical expertise, art therapists are often more comfortable than art teachers in working with the most severely and profoundly impaired students, like the boy on a ventilator seen on the **DVD (C)**. As art has become more widely available to people with disabilities, art therapists

Figure 2.7 An art teacher working with a blind child.

often sensitize and train artists and art educators who offer creative experiences. Because they understand both the art process and the disability, art therapists are ideal consultants for other art professionals doing such work.

In 1970, I conducted a pilot art therapy program at the Western Pennsylvania School for Blind Children with a group of youngsters who had multiple disabilities. I worked with a team that included people in art and special education **(Figure 2.7)** as well as students who wanted to become art therapists. Although that program was labeled as recreation and not therapy, due to the then-discomfort among educators with the idea of counseling, it was unquestionably therapeutic in more than a superficial way from the very first individual assessment settings.

Since blind children are so dependent on those who care for and teach them, expressing hostile and anxious feelings was not easy to do verbally. However, given art materials and a safe, contained environment for the children's intense need to express what was troubling them, there was no question that we were doing art therapy. This is evident on the **DVD**, where you see a child with artificial eyes working through the trauma of his 50 previous operations by playing doctor and patient, giving himself a shot **(D)**. The program itself can be seen in the film *We'll Show You What We're Gonna Do!* which has been remastered and is available on a **DVD** including a videotaped introduction, as well as on a later videotape by Susan Aach **(Figure 2.8)** about her work with higher-functioning children at the school, *Creating, For Me*[3] (in Rubin, 2008d).

Figure 2.8 Susan Aach working with a blind child.

In fact, within a year of that initial program, an art therapist, a dance therapist, and a clinical social worker had been hired to help the children and their parents. So the following summer when parents were offered a six-week art therapy experience, with parallel groups for them and their children as well as joint sessions, they were quick to sign up and participated with the same kind of relief evident in the work with their children, in individual pairs **(E)** and as a group **(F)**.

Medical and Rehabilitation Settings

There is a similar kind of tension about roles and territory when artists-in-residence work in hospitals or rehabilitation settings with the mentally or physically ill. In 1969 a New York group named Hospital Audiences, Inc. (HAI), started bringing musical performances to patients who could not attend concerts. Later, they offered activities in all art forms as well.

Their art workshops, seen on the **DVD (G)**, are still available for those with chronic mental illness and are offered by sensitive artist teachers. The organization, which continues to do excellent work in bringing the arts to many who would otherwise not have access, has extended its work to others for whom arts performances and activities are therapeutic, such as youth at risk for violence in inner city schools and detention centers. Its mission, to "inspire healing, growth and learning through engagement in the arts for the culturally underserved,"[4] continues to be accomplished with ever-increasing support and outreach. Fortunately, there is now an art therapist on the staff who can consult with and train those artists and teachers working in the community. Some of the HAI artists are most impressive **(H)**.

On the Task Panel on the Role of the Arts in Therapy & Environment of the President's Commission on Mental Health in 1978 to which I consulted, there were deep philosophical differences about how best to help troubled individuals through art. Several panel members agreed with Joan Erikson, developer of an activities program at Austen Riggs, a residential treatment center (J. Erikson, 1976). Erikson felt that artists and craftsmen were the best people to bring creative activity to the mentally ill, arguing that using art as a form of therapy interfered with its intrinsically healing power.

The art *as* therapy approach is actually quite close to Joan Erikson's position. It assumes, however, that deeper clinical understanding, rather than interfering, *facilitates* an artist's work with vulnerable patients. As its main spokesperson, Edith Kramer, had written:

> The artist who applies modern psychology in the field of art has to adapt his methods to the medium so that the therapeutic value of art is heightened and reinforced by the introduction of therapeutic thinking, not destroyed or weakened by the introduction of concepts and methods that might be incompatible with the inner laws of artistic creation. (1958, p. 6)

On the **DVD** you can see Edith Kramer doing an art assessment with a young boy **(I)**.

Potter/poet M. C. Richards, while not an art therapist, was in favor of using art in therapy:

> Not everyone agrees that art should be used in a therapy situation. Some artists, some teachers, some doctors think it is demeaning to the seriousness of art to apply it as a kind of medicine or mending tape. I think they are wrong… . Artistic experience is central to the human being and where it is sleeping, it should be awakened however modestly—for it is the person who will awake—and be strengthened—and aided in his growth and development. (1973, p. 32)

In any case, after heated debate and covert anxiety about sharing the territory, a broad set of recommendations was articulated by the Task Panel and the healing potential of a wide range of possible art interventions was made explicit in the panel's report.

*Medical Art Therapy and Arts Medicine (***DVD 2.4***)*

Twenty years later, an even greater openness to avenues of healing through the arts is evident in a growing movement in both the United States (Palmer & Nash, 1991) and Great Britain, sometimes referred to as "Arts Medicine" (Graham-Pole, 2000; Kaye & Blee, 1996; LeNavenec & Bridges, 2005; Rollins, 2004; Senior & Croall, 1996). The program at Shands Hospital in Gainesville, Florida, seen on the **DVD**, is a fine example **(A)**.

Within the last decade, one of the most rapid areas of development is that reflected in the remarkable growth of the Society for the Arts in Healthcare (SAH).[5] Founded in 1991, it is reported that, in part due to the efforts of this group, the majority of health-care settings in the United States now have some kind of arts programming. This ranges from performances, often at the bedside, to a variety of expressive activities for individuals and groups. Because work in the hospital and other health-care settings is often conducted or supervised by art therapists, it is not surprising that the SAH board of directors has always included art therapists as well as physicians, artists, administrators, and supporters.

Parenthetically, academics in Thailand are currently in the process of developing both training and service programs. The planning is a collaborative effort by the School of Fine Arts, the School of Nursing, and the School of Public Health of Burapha University. This is quite different from the development of art therapy in both America and England, which began primarily in mental health settings, although some art therapists worked in schools for children with disabilities. As a member of the advisory board for the Asia Pacific Art Therapy Center at Burapha University near Bangkok, I have been privileged, along with other art therapists, to help guide its development, which will include training for nurses and other health-care professionals in the therapeutic use of art in their own work.

These recent developments suggest that in the future there will be many kinds of people in more and more medical settings offering art activities to patients, a welcome development in helping those in pain and suffering when they need it. There is a spectrum of possibilities,

all of which are valid and useful. What is important is to be clear about the differences among the different art providers groups in preparation, experience, and competency.

In other words, someone helping hospitalized patients to paint might be a nurse, a volunteer, an artist, a teacher, or an art therapist. The difference among them is found primarily in the *goals* of the activity that are intimately related to the provider's background. A volunteer, even one with no art background, can be taught to offer a pleasurable and diverting painting activity. The volunteer's primary goal might be to increase the quality of life for a nursing home resident, and if the patient has a pleasant painting experience, that is certainly a wonderful distraction.

A teacher or artist-in-residence is able to provide instruction (Rollins & Mahan, 1996; Darley & Heath, 2008). Their goal might be to increase the student's self-esteem, which will be enhanced through mastery of the skills necessary to paint effectively. These are all worthwhile goals and, indeed, are what happens when anyone offers art materials successfully in a medical setting.

The art therapist, while also providing creative experiences that promote joy, mastery, and self-esteem, has other skills that are a substantial part of her training, especially in her supervised clinical work. Perhaps most critically, art therapists have considerable experience in the difficult task of reaching profoundly disabled individuals in both educational and medical settings. They therefore tend to be more effective in helping people with Alzheimer's disease, for example, to initiate and develop creative activity (Abraham, 2004; Magniant, 2004; Waller, 2002; Weiss, 1984).

Moreover, an art therapist can use art activities to assess, to treat, and to remediate those psychological problems that interfere with adaptive functioning, which might include being able to use art media or to attend a painting class offered by an artist. Because they are trained in psychology and psychotherapy as well as in art, and are educated in creative ways of understanding and helping others, art therapists can provide a specific kind of service in medical settings that is qualitatively different from others who offer art. This can be seen on the **DVD**, where an art therapist works with a person who has AIDS **(B)** (Malchiodi, 1999a, 1999b; Waller, 2002).

Room for All: Teamwork (DVD 2.5)

I have no question that participating in art activities can be therapeutic in the broad sense of being "helpful," regardless of the background of the provider. Just as there is room for more than one approach in providing art to individuals with disabilities or to people with mental and physical illnesses, so in work with hard-to-reach individuals, a team of arts professionals is often ideal. I say this because pragmatically, there will never be enough trained art therapists to serve the many people who could benefit from the healing power of art. I believe that the most inclusive stance is best not only for those in need, but also for arts professionals who learn and grow when they work collaboratively, spreading the benefits of art expression even more widely. Some instances may clarify.

In 1973, I coordinated a creative arts program for poor children, who are at increased risk for social and emotional maladjustment. The program was funded by Pittsburgh Model Cities (part of a national War on Poverty), and was administered through my employer, the Pittsburgh Child Guidance Center.

Since I was not restricted to hiring people from any specific discipline, I chose individuals with the personal and professional qualities that seemed most critical. The result was

a team of twenty staff members—artists, arts educators, and arts therapists. All of them shared a sensitivity to the cultures of the children and families who lived in the neighborhoods being served. Equally important, all had experience and skill in helping others to create in their particular art form.

A film, *Children & the Arts* (in Rubin, 2008c), showing that program and the value of the arts for youngsters was first produced in 1974 and has recently been remastered for a **DVD** on *The Arts as Therapy for Children* (Rubin, 2008c) including two additional features: one about an art program for orphans and malnourished children in Guatemala conducted by an art therapist, and the other produced by Very Special Arts of Massachusetts about healthy ways of introducing different arts materials and activities. Excerpts from the *Introduction* to the remastered version of *Children & the Arts* can be seen on the **DVD (A)**.

For four years (1993–1997) I worked with an established organization, the Pittsburgh Center for the Arts, to develop a Community Arts Education Network. Like other art therapists, I functioned in a variety of roles, depending on the need. I was a consultant to a weaving program for people with chronic mental illness, a photography program for delinquent teenagers **(Figure 2.9)**, a workshop on healing art for cancer patients, and an arts enrichment program for alienated adolescents. I also co-led group therapy with a drama therapist for women in an addiction rehabilitation program referred to earlier in this chapter.

As noted earlier, there can and should be room for artists, art teachers, and art therapists, since each has special skills to offer. And people with problems—mental, physical, socioeconomic—deserve all the help they can get, whether their difficulties are temporary or chronic. Happily, multidisciplinary efforts are happening more often to meet the pressing human needs of our time.

I am convinced that art can be therapeutic not only in clinics and hospitals, but also in schools, studios, prisons, and shelters—wherever there is a need. The world is filled with people who, especially when in crisis, could reap the therapeutic benefits of creating art if it is offered in a respectful and sensitive way. I believe that we can best extend our reach by building bridges with others whose values reflect our own.

Figure 2.9 A teenage photographer in a program at an arts center.

I have long admired two programs that rely heavily on volunteers to serve the needs of children who have been traumatized. One of these is Free Arts for Abused Children (FAAC), which began in 1977 when individuals who had worked with at-risk children set out to reach them through art. The volunteers are trained and supervised by art therapists (www.freearts.org). On the **DVD** you can see art therapist Elda Unger, one of the co-founders, teaching a group of volunteers **(B)**.

The other is DrawBridge, a program that has been serving homeless children since 1989. It was founded by Gloria Simoneaux, seen on the **DVD (C)**, an artist with clinical training and a Registered Expressive Arts Therapist (www.drawbridge.org). Both of these programs have expanded considerably, with organizations in other cities in the United States and in Africa **(D)** modeled on the originals. Both provide art programs for vulnerable youngsters in a way that strengthens their sense of joy and self-esteem, and both work to strengthen family ties as well.

No matter how many professional art therapists we may eventually train, we will never be able to fill the vast human need for the healing power of creative expression. I hope that art therapists will be willing to share their expertise with others whose values are synchronous with our own. Although others may disagree, I am convinced that collaboration will ultimately serve to strengthen the discipline of art therapy.

Art Therapy and Child Therapy (DVD 2.6)

Play Therapy and Child Art Therapy

There is understandable confusion about the distinctions between play therapy and art therapy with children. Here, too, the differences are not always visible on the surface. A session of art therapy with a child or a group might look very much like play therapy, especially if there is any media exploration or dramatization. This is true in several vignettes in Chapter 1, like those about Alan and Jeff. Art and play are closely related, since playfulness is part of any creative process, and there is considerable artistry in good play therapy.

These commonalities are, however, analogous to the educational aspects of art therapy and the therapeutic aspects of art education. In art therapy and art education, the *modality* (art) is the same, but the *goal* (therapy vs. education) is different. In the two types of child therapy, the *goal* (therapy) is the same, but the *modalities* (art vs. play) are different.

Even when dramatic play occurs in art therapy with children, there are still distinctions between art and play therapy. Although most play therapists provide some art materials, they are usually offered along with a range of other play equipment. A recent collection of "favorite play therapy techniques" included many that used art media, but usually in structured activities designed for specific purposes. Art therapists are more likely to foster free self-expression, even when specific tasks are utilized. Art therapists also generally provide a greater variety of art materials, and are able to teach children how to use them effectively.

However, as art therapy has become better known, there are creative clinicians who have wanted to learn what we have to offer. At least one prominent play therapist, Eliana Gil, trained in art therapy and became an ATR, so that she could better understand how to interpret what her patients created and how best to help them (Gil, 2006a, 2006b). You can see and hear her on the **DVD (A)**. Another edited a book on using the expressive arts to help trauma survivors of all ages (Carey, 2006) to which I contributed the Foreword.

In other words, since play therapists had art materials in their playrooms long before the development of the profession of art therapy (Moustakas, 1953, 1959; Rambert, 1949),

there is considerable overlap. I suspect that the purchasers of *Child Art Therapy,* a book that first appeared in 1978 and has recently been revised (Rubin, 2005b) include child therapists with a fondness for using art and other creative modalities. I also imagine that those who help children via play therapy are among the users of a creative drawing book distributed by the American Psychological Association, designed for children whose parents are separated and divorced; it is called *My Mom and Dad Don't Live Together Anymore* (Rubin, 2002) **(B)**.

Pediatric Art Therapy and Child Life Programs

There is also some overlap and interaction between art therapy with young people and pediatric art therapy, as well as a field that is almost as young as art therapy—child life. In the past, most play programs in hospitals for children were staffed by volunteers. In 1964, a child development student running one at Children's Hospital in Pittsburgh asked if I would teach the volunteers how to use art in their evening activities. In 1971, an art therapy intern traveled the wards, offering art materials and support to children before and after surgery, as well as during long hospitalizations **(C)**. And a *Hospital Drawing Book* (Rubin, 2009) was such a success that we were able to retrieve only one finished copy since the children wanted to take them home when they left the hospital.

Perhaps because of these earlier efforts, the director of the first child life program at that hospital requested in-service training in art therapy for her staff. And in October 2008, another workshop was held for the much larger staff of child life specialists and assistants, who then used art with the pediatric patients under supervision. A follow-up session was held in December 2008.

The Child Life Council (CLC), founded in 1982, grew out of earlier efforts to help hospitalized children to cope (www.childlife.org). It is a multidisciplinary organization that promotes the psychosocial well-being of children and families in health-care settings. Child life specialists are eligible to take a certification exam at the bachelor's level after 10 college courses that may be in any combination of relevant areas (psychology, therapeutic recreation, etc). Like many developing professions, including art therapy in its early organizational years, it has not yet solidified an identity.

Since the vast majority of those certified in this field have not had specialized supervised training, their preparation is not comparable to that of medical art therapists who work in hospital settings (Malchiodi, 1999a). Like play therapists, they are likely to offer a wide variety of materials and toys, especially those used in and related to hospital procedures. While art may be among the activities they offer, it is not primary.

Because of the obvious overlap, many art therapists have been directly involved in this area and will no doubt continue to be **(Figure 2.10)**. Diane Rode, credentialed as both an art therapist (ATR-BC) and a child life specialist (CCLS), directs the Child Life Program at Mt. Sinai Hospital in New York, where she supervises a large multidisciplinary staff. At Dartmouth Medical Center pediatric residents have learned to offer art activities to children in the hospital **(D)**.

Art Therapy and Art Counseling

Another overlapping area of work is occasionally referred to as *art counseling. Counseling* was formerly used primarily to refer to guidance, especially in educational and rehabilitation settings. More recently the term is less often a synonym for *advice* and more often for *psychotherapy*. Counselors, who may have a general clinical background or may be trained in pastoral or rehabilitation counseling, tend to be employed in education or rehabilitation

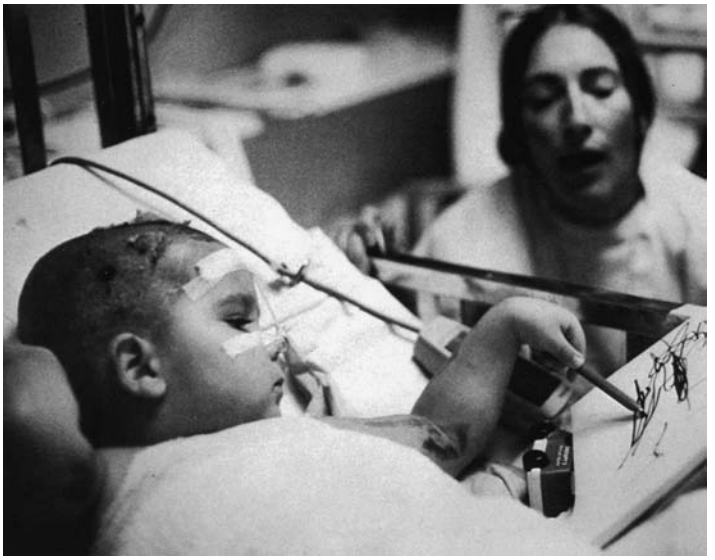

Figure 2.10 An art therapist works with a pediatric burn patient.

settings and specialize in many different areas. Those with an affinity for visual expression have integrated art into their work.

John Allan, who called what he did "art counseling," worked with schoolchildren in Vancouver and authored two books describing ways of using art and writing to help children in schools (Allan, 1988; Allan & Bertoia, 1992). The American Counseling Association has recently published a third edition of a book on the use of the arts in counseling (Gladding, 2005). For many years, the George Washington University Counseling Center offered art therapy to students. On the **DVD** (**E**), you can see an excerpt from a session conducted by Sondra Geller.

A relatively recent development in the field of art therapy, designed primarily to help students to secure licensure, is the addition of counseling courses to the curricula required for master's training programs approval. This is felt to be compatible because understandings and skills in both assessment and therapy are basic to being a competent art therapist, and calling them "counseling" as it has developed in the United States is a realistic way for graduates of training programs to be able to practice their specialty under umbrella counseling license bills.

Other Clinicians Who Use Art (DVD 2.7)

Art Therapy and Occupational, Recreation, and Activity Therapy

There are many superficial similarities between art therapy and ancillary treatments that use art activities. In the 1960s, occupational therapy (OT) departments were usually psychodynamic in orientation. Since such approaches stressed the dangers of repression and the values of expression, it was natural that art activities were central in OT **(A)**. *Hands* is a 1962 film about a woman in a psychiatric hospital whose progress is reflected in the sculptures she created in occupational therapy **(B)**.

When I was asked to consult to the large and well-equipped OT program at Western Psychiatric Hospital & Clinic in 1969, art therapy pioneer Margaret Naumburg advised me

not to do so. She was in favor of my consulting to the new Day Hospital, because what they were doing was "real therapy" (group psychotherapy).

There was much overlap at that time between art and occupational therapy in materials and approaches, and pioneers like Naumburg feared that the young field might be engulfed by its more powerful older sibling. Occupational therapy has since become less psychodynamic, and has moved away from its earlier emphasis on arts and crafts activities. Nevertheless, many art therapists began their careers under the job title and/or the supervision of an occupational, activity, or recreation therapist.

All of these fields use art as one of many possible activities, forms of recreation, or ways of being constructively occupied. All of them also tend to provide art as an activity for some prescribed purpose, usually specified by the referring physician. Although the social and emotional well-being of the patient is of interest to other activity-based therapies, art therapists focus on the psychological aspect of the work. In addition, these other therapies are always adjunctive, while art therapy often is not.

Art therapists—because of their greater familiarity with media and processes—can serve as resources for these other professions, and can learn from them as well. The woman who taught crafts to the same hospitalized children I saw for art therapy in 1963 had been trained in occupational therapy. She taught me *task analysis*, a method of breaking a task into its smallest components. This kind of thinking is especially valuable in selecting, offering, and evaluating art activities for those with neurological impairment and/or developmental disabilities.

The Creative & Expressive Arts Therapy Department (CEAT), which my drama therapy colleague and I initiated in 1981 at the Western Psychiatric Institute & Clinic (WPIC), actually *replaced* Occupational Therapy **(C)**. The group of clinicians I currently work with, who are under CEAT, includes not only individuals trained in art, dance, drama, music, and poetry therapy, but also a recreation and an activity therapist as well.

Therapeutic recreation is indeed just that, and is very helpful to people who are in a psychiatric hospital. The activities offered by these professionals greatly relieve tension and are part of a healthy therapeutic inpatient diet. While they are interested in using art materials as well as many other kinds of tools in their work, it is clear to me that their goals are as different as the titles of their disciplines would suggest.

Occupational therapy has developed during the time since CEAT replaced the department at WPIC into a field whose primary focus is on helping patients to resume activities of daily living. It has returned to both inpatient and partial hospitalization programs as a useful resource.

The creative arts therapies are used throughout the continuum of psychiatric care, from inpatient to partial to outpatient. In addition, CEAT is currently moving into other settings, including the strictly medical components of the University of Pittsburgh Medical Center, such as the Cancer Center and the Children's Hospital.

Art Therapy and Others Using Art in Psychotherapy

Art therapy is more similar to other psychotherapeutic approaches that use art materials than to its activity therapy relatives. For example, projective drawing tasks were originally the province of clinical psychologists (Hammer, 1958; Kinget, 1952; Koppitz, 1968; Machover, 1949). And despite the fact that their validity and reliability has been demonstrated repeatedly to be uncertain, they have continued to be popular (Burns, 1987, 1990; Burns & Kaufman, 1970; Hammer, 1997; Klepsch & Logie, 1982; Koppitz, 1984; Gillespie, 1994: Liebowitz, 1999).

Art therapists also are likely to use drawings as sources of information (Brooke, 2004; Malchiodi, 1998a). Although some have focused on a single prescribed task (e.g., Gantt & Tabone, 1998), most art therapy assessments have involved a series of tasks (Levick, 1983, 1986, 2001; Silver, 2001, 2002), as in the Diagnostic Drawing Series developed by Barry Cohen and his collaborators (www.diagnosticdrawingseries.com). Most art therapy drawing assessments are very different from the psychologists' standard house-tree-person or human figure drawings, often offering a larger space on which to draw and colorful drawing materials (cf. Kwiatkowska, 1978). (See Chapter 6, this volume.)

Psychodynamic therapists have been especially attracted to the use of art in their work because of the ability of imagery to bypass defenses. Indeed, many were using art to assess and to treat people long before the profession of art therapy was defined and developed as a separate discipline (cf. Bender, 1952; Jakab, 1956/1998; Milner, 1969, 1987; Winnicott, 1971a, 1971b). And since art materials can be used by a wide range of people without specialized training, it is no wonder that many clinicians have offered art media to those they are interviewing, like child psychiatrist Robert Coles (1992) **(DVD 2.8)**.

With the increasing interest generated in part by the growth of the field of art therapy, even more clinicians are interested in incorporating art into their practice. Indeed, there has long been a division within the American Psychological Association (APA) named the Society for the Psychology of Aesthetics, Creativity, and the Arts (www.apa.org/divisions/div10), which, while it emphasizes experimental aesthetics, also includes psychologists interested in clinical applications.

In addition, the American Counseling Association (ACA) has a recently initiated division, the Association for Creativity in Counseling (www.aca-acc.org). The ACA bookstore has not only distributed *Art Therapy Has Many Faces* (Rubin, 2008a) since it was released, but screened it in a conference film festival in 2007 and 2008.

When I first began work at the Pittsburgh Child Guidance Center in 1969, most of the social workers who saw children used art materials in activity group therapy. In fact, part of my job was to acquaint them with a wider range of good quality media and ways of offering art that would be most successful. This included what to do with the work that was produced; that is, ways of reflecting on it, especially verbally. I was also asked to do workshops for other clinicians who needed help offering and inquiring about art.

In fact, since retirement from practice I have continued to meet with the Child Psychiatry Fellows for an annual workshop. Having therefore spent much of my teaching career at the University of Pittsburgh instructing trainees in other mental health disciplines, I finally decided to write the book called *Artful Therapy* (Rubin, 2005a) for non-art therapist mental health professionals.

Since they are increasingly interested in using art, imagery, and other creative modalities in their work, but often have little background or access to help, it was my feeling that they would be more successful with a bit of advice on how to do so effectively. That book does not aim to make other clinicians into art therapists; indeed, it includes a chapter about the profession and examples of ways in which readers might make use of the services of an art therapist.

I suspect that another reason for the increased interest of others in the use of art is the fact that more and more patients have suffered trauma of some sort, where nonverbal methods are most effective in accessing memories buried in the body and no longer conscious. This is a population well served by art therapy, a fact that is evident in the rapidly growing literature dealing specifically with its use with survivors of abuse and other kinds of trauma (Arrington, 2007; Brooke, 1997, 2007; Carey, 2006; Gerity, 1999; Gil, 1991, 2006b; Hagood,

2000; Kluft, 1993; Klorer, 2000; Meijer-Degen, 2007; Milia, 2000; Miller, 1986; Murphy, 2001; Schreiber, 1974; Simonds, 1994; Spencer, 1997; Spring, 1993, 2001; Tinnin & Gantt, 2000).

The number of recent books attests both to the increase in this patient population and the awareness by clinicians that the arts are vital in helping those who have been traumatized. These patients desperately need a way of "telling without talking," the title of a book by two art therapists (Cohen & Cox, 1995) about their work with people suffering from dissociative identity disorder (DID), formerly known as multiple personality disorder (MPD).

Art Therapy and Expressive Therapies (DVD 2.9)

It is easy to tell the difference between art therapy and close relatives like music, movement, dance, drama, or poetry therapy—at least when each is offered separately. But there is considerable confusion about approaches that use multiple modalities. Multimodal approaches are usually called by names like "expressive [arts] therapy" or "creative [arts] therapy." Although there are a few individuals with the ability to evoke and to facilitate expression in more than one art form, such people are rare. More often, a therapist has training in one creative art modality, along with an openness to and comfort with others.

The following vignette is about the close relationships among all expressive modalities that comes naturally to young children. It is also present in adolescents and adults, who simply need more help to access their creativity. Although Carla's treatment was primarily through art, she also used drama and filmmaking in her therapy.

Expressive Arts Therapy Ends Nightmares: CARLA (8)

The oldest of four little girls, eight-year-old Carla had been a pretty happy child. But shortly after the birth of the latest baby, she began to have nightmares almost every night, often wetting the bed as well. Her tired mother brought her to a clinic, and she was referred to me for weekly individual art therapy **(A).** For many months she refused to talk about or to draw her scary dreams, but instead painted beautifully colored "bars" behind which the monsters were hidden **(1).**

One day when she couldn't decide what to make, I suggested a "scribble drawing." Carla must have been ready to find and to represent her "Nightmare Monster," for that is what she made, telling the story as she drew **(2)**. The monster caught first one little girl, then another, then Carla too. After showing all three girls in the monster's clutches, she drew one yelling "Help!" Picking up a red tempera marker, she pounded vigorously on the paper, calling the blotches "soldiers," whom she hoped would be able to rescue the children. Throughout most of the drama, Carla was uncertain about the outcome. At the very end, however, she declared with relief that the soldiers would win and the monster would be killed **(Figure 2.11)**.

For months Carla drew monsters of all shapes and sizes, using a variety of media **(3)**. For a while, she cut out the monster drawings and placed them inside cut-paper cages she had carefully constructed. And for two weeks she insisted that the caged monsters be locked in my desk drawers. As Carla became more familiar and comfortable with these images, it was possible for her to extend the fantasy in dramatic play.

One week she spontaneously used soap crayons and painted my face as the nightmare monster, asking me to pretend to attack her. The following week, she reversed roles and became the monster, attacking me as the fearful child **(4)**. It was during this period that the nightmares stopped. Art allowed Carla to *see* the scary-mad monster, while drama allowed her to safely *feel* her anger.

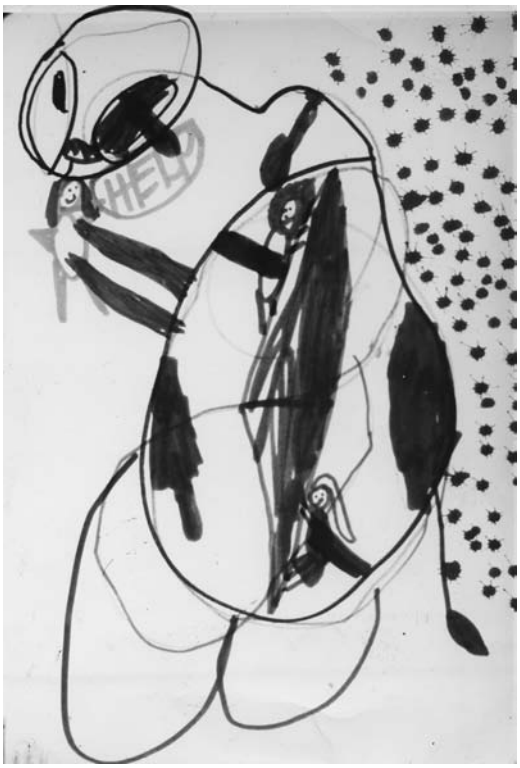

Figure 2.11 Carla's nightmare monster.

She continued to come every week. When she had become more comfortable with her angry feelings, she worked more on issues of identity, and when it was decided that she was ready to say goodbye, on attachment and separation **(5)**.

It was not easy for this little girl, the oldest of four with an immature mother and absent father, to give up her special friend at the clinic; but given half a year and the ability to set the final date herself, she managed to work through the hurt she felt. In the course of feeling angry at me for abandoning her by "kicking her out," she was frequently reminded of her early monster dreams, play, drawings, and feelings.

Carla decided that for her last project she would make a film about how monsters are really make-believe, so that I could show it to other children who might come to the clinic in the future with fears such as hers. Using an 8 millimeter camera, tripod, light, and simple animation techniques, Carla cut out monsters **(6)** that magically moved around the walls, scaring a little girl who was at the sink. After this, the girl came to see me, we returned to look at the heads together, and presto! They had disappeared! **(7)**.

Making the film was a creative and effective way for Carla to review the main problem for which she had been in therapy, to remind herself of what she had learned, and to deal with her envy of future patients (siblings) by intruding into their space in a most acceptable way—making a film to help them and thus transforming her jealousy into generosity.

Mixing Modalities in Treatment

My own experience with other expressive arts therapists began in a study group. The group, which had been organized by a child psychiatrist, also included a drama and a dance therapist,

Figure 2.12 Participant in Parent Play group.

as well as psychologists and social workers interested in the arts. We initially worked *side by side* with the same children in a therapeutic day camp, and later *jointly* in art-drama groups **(B)** with children **(1)**, adolescents **(2)**, and adults, as well as Parent Play **(Figure 2.12)** groups **(3)**. The *Green Creature Within* (in Irwin & Rubin, 2008) is a film my drama therapist colleague and I made about the adolescent group **(4)**.

In such an interdisciplinary mix, it was natural to want to learn from one another. As a result, I added simple musical instruments **(5)** and dramatic play equipment like puppets, dolls, and props to the art materials in my playroom **(6)**. Nevertheless, while the children were able to use the others spontaneously, I was still best at facilitating expression with art materials. My colleague, Ellie Irwin, similarly added art materials to her playroom **(7)**, but she was more skilled at helping children in drama.

There have been a few individual art therapists who have been able to facilitate expression in more than one modality. At the 1973 conference, for example, art therapist Mildred Lachman (Chapin) who was also a trained dancer, offered a workshop called The Use of Movement in Art Therapy **(C)**. At the 1976 conference, Harriet Wadeson described "combining expressive therapies" in an "experience group" for adults in long-term psychiatric hospitalization, something that was common in the era before effective antipsychotic medications. Her *multimodal group*—using relaxation exercises, movement, music, drama, fantasy, and art—seemed to be the only way to reach these severely withdrawn patients.

Sharing and Collaborating

The trend in art therapy *training* programs has been to focus on expertise in the visual arts, though some have fostered exposure to other expressive modalities as well. Many service programs have also expanded to include more than one creative arts therapy. A similar process is reflected in the story of one journal, which began in 1973 as *Art Psychotherapy*. First, articles in other creative arts therapies were accepted, then there were separate editorial boards, and in 1980 the name was changed to *The Arts in Psychotherapy*. The stimulation of cross-fertilization is a major fringe benefit of communication. This is evident in recent books from Great Britain, which include chapters by art, music, dance, and drama therapists on practice, training, and research.

Despite the fears of some individuals that involvement with other groups would dilute or contaminate art therapy, the advantages of working with music, drama, and dance therapists are great. In addition to the expansion of service and training programs, political coalitions have been formed, and have been quite effective. Although some worried that the natural rivalry of creative arts siblings for jobs and recognition would be destructive, that has not generally been the case.

The National Coalition of Creative Arts Therapy Associations (NCCATA) was formed in 1979. The member groups of NCCATA have worked together, holding joint conferences (1985 and 1990), as well as regular meetings to address common political concerns. While a closer administrative relationship among the member organizations has been proposed, it has yet to occur. Cooperation for political and economic purposes has been acceptable to all members of the coalition, but an underlying tension between autonomy and collaboration remains (Johnson, 1999). In European coalitions, relationships among the different creative arts therapies seem to be similarly ambivalent. The ongoing debates concern both practical and philosophical issues.

Training Issues

Many art therapy educators have questioned the feasibility or desirability of training students in more than one creative modality. Most have expressed anxiety about producing shallow dilettantes, though some have become more comfortable with multidisciplinary approaches.

Two training programs in the United States were in *expressive* therapies from the start (Lesley College and the University of Louisville). Several others have since added training in other art forms, including the Pratt Institute, whose founder has long argued for an *expressive therapy* approach (Robbins, 1980, 1994). Lesley now awards degrees not only in specializations like art therapy, but also in expressive therapy.

One of the first art therapists to advocate a multimodality approach was Shaun McNiff, whose training program at the Institute for the Arts & Human Development of Lesley College was in the expressive therapies from its inception in 1974. McNiff (1981, 1986) described his rationale for a multimodal approach to expression and training, noting its roots in *shamanism* and ancient healing rituals **(D)** (McNiff, 1994, 2004). His colleague, Paolo Knill **(E)** also argued for an interdisciplinary approach, which he has referred to as "Intermodal Expressive Therapy" (Knill, Barba, & Fuchs, 2004), as well as "Expressive Arts Therapy" (Knill, Levine, & Levine, 2005). Knill and his colleagues, like Steven Levine (1992) and Ellen Levine (2003), agree with the critics that a superficial acquaintance with different techniques is meaningless, stressing instead what they call *intermodal* understanding, comparing it to art forms like opera, film, or performance art.

The Levines run an integrated arts therapy training program in Toronto under the auspices of the International School for Interdisciplinary Studies (www.isis-canada.org). There is, in fact, a growing network of expressive arts therapy training centers in both institutes and universities training people in a multimodal approach in many countries. The universities include not only Lesley, but also the California Institute of Integral Studies (where Natalie Rogers has taught) and the European Graduate School (founded by Paolo Knill). In 1995 the International Expressive Arts Therapy Association was organized, with members who are artists, educators, and therapists (www.ieata.org).

Although most art therapists are still trained and skilled primarily in the visual arts, there is unquestionably a greater openness to the use of other art forms than in the past. This is reflected in the literature, with many recent books containing chapters by art, drama, dance, music, and poetry therapists (Betts, 2003; Brooke, 2007; Camilleri, 2007; Carey, 2005;

Darley & Heath, 2008; Dokter, 1994, 1998; Frostig & Essex, 1998; Hornyak & Baker, 1989; Innes & Hatfield, 2001; Kluft, 1993; LeNavenec & Bridges, 2005; Levy, 1995; Payne, 1994; Seki, 2008; Waller, 1999, 2007; Waller & Mahony, 1999).

Two deal with all of the expressive/creative arts therapies, each with contributors from each art form (Brooke, 2006; Malchiodi, 2004). Others consider the relationships among the different approaches (Feder & Feder, 1981, 1998; Johnson, 1999; Jones, 2005; Karkou & Sanderson, 2006; Warren, 2008).

Choosing a Multimodal Approach

Certain groups naturally evoke multimodal expression. In my work with young children **(F)**, related modalities often emerged spontaneously, as with Carla. A child might use finger paint as make-up, and create a role **(1)**. He might create a prop, like a sword, and then use it to attack in a drama **(2)**. Or she might pick up a clay sculpture and start to speak for it as if it were a puppet, as Terry did with her horsie **(3)**.

Violet Oaklander, a Gestalt therapist, has used art and other creative modalities in her work with children and adolescents **(4)**. And Natalie Rogers, who first worked as a play therapist, has advocated the use of all of the arts with people of all ages in an approach she calls the "creative connection" (Rogers, 1993) **(G)**.

In addition to population as well as personal and philosophical predilections, geographic isolation and the search for kindred spirits is probably a factor in the adoption of a multimodal orientation, as with CREATE in Toronto. In Pittsburgh, for example, there were so few creative arts therapists that in 1973 we founded a multi-arts organization, the Pittsburgh Association for the Arts in Education & Therapy (PAAET), which is still going strong.

One of our colleagues at the Pittsburgh Child Guidance Center was Penny Lewis, author and editor of publications on both dance and drama therapy. She later published another in which she used art, drama, and music as well as movement (Lewis, 1993). Penny's embrace of multiple creative modalities **(H)** may have been enhanced by the groups she and I co-led with Ellie Irwin, our drama therapist colleague.

A multimodal expressive therapies approach seems to many to be as natural as children's play or religious ritual. But it is not for every client or for every practitioner. It has always been popular in the "human potential" movement, from its early beginnings in the 1960s to its revival in the 1990s. This is evident in the numerous multimodality arts workshops offered at growth centers like Esalen or Omega, and described in periodicals like *Common Boundary*.

In 1981, Ellie Irwin and I were asked to develop a department at the Western Psychiatric Institute & Clinic (WPIC). We chose to have a multi-arts therapy team, and hired music, dance, drama, and art therapists. We called it CEAT (Creative & Expressive Arts Therapies) because we couldn't choose between the richness associated with both *expression and creation*. An article written about our program was entitled "Words Can't Say it All." One book on expressive art therapies was subtitled *When Words are Not Enough* (Levy, 1995). As we had by then discovered in our clinical work many times over, no single art form says it all, or is right for every person or for every purpose.

There is as yet no consensus about the meaning of terms like *expressive* or *creative* therapies. As they are currently used, they deal with two different phenomena. One involves arts therapists from distinct disciplines working together collaboratively (Jennings & Minde, 1993). The other is a genuinely integrated expressive arts approach by an individual therapist, who offers more than one modality (Lewis, 1993; Gong, 2004; Rogers, 1993).

And since the word *art* can refer to all creative modalities, there are even times when "art therapy" means "arts therapies." Similarly, there are times when *creative therapy* refers not to many art forms, but to one alone. To Hauschka (1985), for example, "artistic therapy" means "painting therapy."

Concluding Thoughts

Despite the fact that many in the field seem to feel remarkably proprietary, art therapists do not *own* art, any more than they own *therapy*. What they do have to offer—what is unique—is a highly developed expertise in the use of art as a central modality in therapy. This is true whether the art therapy is adjunctive to verbal psychotherapy, or is the primary treatment itself. At first, art therapy was usually adjunctive, though it was sometimes used by psychoanalytic clinicians as a major form of expression in treatment. Increasingly, art therapists are functioning as primary therapists, probably because of the growing sophistication of trained art therapists, as well as changes in human service delivery.

As for the many others who also use art in healing, Elinor Ulman pointed out long ago that "Painting and sculpture are subject to such a broad range of therapeutic and educational applications, that the boundaries between art therapy and other disciplines are inevitably blurred." She also observed that "patients are not ordinarily concerned with professional distinctions, so they will occasionally turn out sculptures in occupational therapy sessions and make ashtrays in the art room." Ulman's parting words were that all those "who use art in their practice must live with the task of sharing their common ground as peacefully as possible and must learn to respect each other for the special knowledge and skills that are unique to each professional group" (Ulman, Kramer, & Kwiatkowska, 1977).

Art + Therapy = Art Therapy

The definitions of art therapy currently offered by both the American Art Therapy Association (AATA; www.arttherapy.org) and the British Association of Art Therapists (www.baat.org) allow for a wide range of activities, with varying degrees of emphasis on either component of the mix. There is clearly a continuum in the use of art for therapeutic purposes, from the intrinsically healing experience of the creative process to the diagnosis and treatment of specific conditions. Although the debate about the definition of art therapy continues, most practitioners would agree with Elinor Ulman that whatever is called "art therapy" needs to be true to both art and therapy.

The history of the discipline, like the history of an individual or a family, is an excellent way to understand how art therapy came to be what it is today. In 1980, the late psychologist Rudolf Arnheim gave the keynote address at an AATA conference. Although his own interest was in the psychology of art (Arnheim, 1954, 1967, 1969), Arnheim had been a supporter of the early work of pioneer Margaret Naumburg in the 1940s and the supervisor for Shaun McNiff's graduate work in the 1970s. In other words, Arnheim, himself a wood sculptor (Gypsycat Productions, 1994), had been around art therapists and art therapy from the inception of the discipline.

His understanding of our genetics was simple: "Psychology and art may be called the father and the mother of art therapy." The next chapter will look more closely at the broader question of our complicated heritage, asking "Where did art therapy come from?" and examining the *origins* of art therapy and the *history* of the profession.

Endnotes

1. From "Art Therapy: Problems of Definition," by E. Ulman, 1961, *Bulletin of Art Therapy*, *1*(2), 10–20.
2. From "The Power of Art in Therapy," by E. Ulman,1971, in *Psychiatry and Art*, Vol. 3, Ed. I. Jakab. New York: S. Karger, pp. 93–102.
3. Available from EMI (www.expressivemedia.org) on *Art Therapy with Blind Children* (Rubin, 2008d).
4. Hospital Audiences, Inc., www.hospaud.org/hai/index.htm.
5. Society for the Arts in Healthcare website: www.thesah.org.

CHAPTER 3

History

Art therapy is not a modern invention.

"If men of worth did know what delight [art] breedeth," wrote Nicholas Hilliard, Court painter to Queen Elizabeth I, "how it removeth melancholy, avoideth evil occasions, putteth passions of grief or sorrow away, cureth rage and shorteneth the times, they would never leave until they had attained in some good measure or more their comfort."

Writing more than 300 years later, Jung made much the same observation: "A patient needs only to have seen once or twice how much he is freed from a wretched state of mind by working at a symbolical picture, and he will always turn to this means of release whenever things go badly with him."

Anthony Stevens, 1986, p. 122

The Sources of Art Therapy

Natural Beauty is Soothing

I believe that the bedrock, the underground source of healing through beauty—whether taking it in or creating it—is not only art, but the natural world from which it springs. Many have found in nature's eternal wonder an echo of something deep in the human soul, whether in the rhythm of the waves, the rustling of the leaves, or the howl of the storm. I have often soothed myself, when too troubled or tired to create, by searching for a peaceful spot where I can drink in the delicate shape and shifting tones of a wildflower, the linear tracery patterns of trees silhouetted against the sky, or the majesty of a brilliantly hued sunset, as on the **DVD (3.1)**.

The power of the aesthetic, the beautiful, to quiet and to calm, to contain even ugly passions, is so profound as to be incalculable. Why else would we derive such joy from natural beauty or such pleasure from the arts? It seems that the nonverbal forms we treasure are so very valuable because they mirror, echo, and express the ineffable, unspeakable feelings we all carry within, from birth until death. And when we touch and shape materials in making art, we experience our impact on the world; indeed, we feel our very existence.

Creating Comes Naturally

Creating seems to be natural to our species, involving a spontaneous impulse, if not an actual need **(DVD 3.2)**. Making marks comes so easily, in fact, to infants and toddlers **(A)** that we were not terribly surprised to learn from anthropologists like Desmond Morris (1962) that our closest animal relatives—apes and chimpanzees—also love to draw and paint, sometimes enough to postpone food or sex while engaged in creating **(B)**. Those that have learned sign language even name their scribbles, just like toddlers.

I once had the good fortune to accompany art therapist David Henley on a visit to the Lincoln Park Zoo in Chicago, where he had been going for weekly art sessions with the animals. **(C)**. Though his chimp friend made it clear that she didn't feel like painting that day, I did get to watch a mother elephant and child painting side by side, brushes in trunks, both rhythmically swishing colors back and forth on the paper.

I had the further pleasure of observing a gorilla named June create a crayon drawing, which I treasure as a memento of the visit **(D)**. June's drawing itself was unremarkable, like a child's scribble. But watching her concentrate on the activity for a full five minutes in a large cage full of noisily playing apes was astonishing. Although I have often seen people similarly absorbed in drawing, I felt like I was witnessing firsthand the primal pleasure of a deep engagement in the creative process.

Art for Healing Is Ancient and Universal

So the origin, the source of art therapy, lies I believe in the natural world. Although its emergence as a newly defined profession is relatively recent, its roots are ancient and universal **(DVD 3.3)**. Prehistoric artists who drew animals on the walls of caves **(A)** or who carved fertility figures, Egyptian painters of protective symbols on mummy cases, Tibetan Buddhist creators of sand mandalas **(B)**, African carvers of ritual masks**,** Byzantine painters of sacred icons, Ethiopian artists who drew on parchment healing scrolls, Zuni carvers of magic fetishes—all represent historical antecedents of modern art therapy.

Like the unconscious mind itself, this source is ever present as a part of the human condition. The "magical thinking" behind such things as faith healing and voodoo effigies is not simply an ancient relic or exclusive to primitive cultures. It is, in fact, present in us all, not only when we are children but eternally, in that part of the mind not accessible to rational thought. It may well be the source of the "placebo effect" and the success of mind-body approaches to healing. What art historian and psychoanalyst Ernst Kris (1952) called the "magic power of the image" is very real for human beings, and we who work with art in therapy know and respect it. Man's profound belief in this phenomenon may even be the primary reason that art has always been so therapeutic.

Equally ancient is the use of symbolic expression in order to heal. In most "primitive" societies, the visual arts are evident in the ritual decoration of body, costumes, masks and other props, the beautification of the sanctuary, and the creation of a setting for the ceremony. More dramatic still is the use of magical visual symbols, such as fetishes, talismans, or sand paintings. Medicine men and shamans have been thought of as the forerunners of modern psychiatrists. They are even more clearly the ancestors of creative art therapists (cf. McNiff, 1994; 2004).

Because of the universality of art making and image-magic, and because of the related power of the symbolic mode, healers past and present have utilized many different art forms in their work. Most healing rituals incorporate the rhythm of the chant, the beat of the drum, the movement of the dance, and the drama of the story, along with the power of many

visual elements. One summer in New Mexico I accidentally came upon a Hopi Rain Dance, an event not normally open to the public. One need only witness such a ritual, with its total and passionate community involvement, to sense the awesome power of the arts in a culture where they are still central and very much alive.

Art Therapy: An Idea Whose Time Had Come

In spite of these deeply entrenched roots, the climate had to be ripe for growth. We would probably not have discovered so many ways of using art in, for, and as, therapy, had not the late 19th and early 20th centuries been so fascinated by the concept of the unconscious **(DVD 3.4)**. This idea was popularized not only in the depth psychologies of Freud **(A)** (1916–1917) and Jung **(B)** (1964, 1972), but also in the novels of James Joyce and the poetry of the French Symbolists.

Artists have always delved within for the source of their imagery as well as their creative power. It was not until quite recently, however, that exploring, knowing, and representing the world within was articulated as a respectable aesthetic goal. Around the time that psychoanalysts were beginning to plumb the mystery of dreams, Western artists were in the process of giving up the representation of the outside world for the mysterious goal of expressing the inner one.

They were attracted to what seemed more pure, less fettered expressions of man's spirit, such as the masks of Africa or the prints of Japan. And they set out—not to reproduce external reality as before—but to reflect the reality of the soul. This was the goal of such artistic techniques as automatic drawing. And it was the essence of movements like Expressionism and Surrealism—to depict emotion through color and line—as in Edvard Munch's *The Scream* **(C)**, or to show the irrational landscape of the dream, as in the paintings of Salvador Dali **(D)**.

Meanwhile, the artist himself was becoming more and more of a social outcast. No longer automatically supported by social structures like the church or royal patrons, he became more starkly than ever the lone seer, a prophet who saw and told of things we didn't always want to know. And perhaps even more than in earlier eras, the artist became a creature of glamour, as did the creative process itself.

Psychiatric Interest in Patient Art

Also during the late 19th and early 20th centuries, some psychiatrists, stimulated by the possibility that what had been thought to be irrational might make sense after all, became fascinated by the spontaneous art of the mentally ill **(DVD 3.5)**. People caught up in the turmoil of a psychotic break, threatened by loss of contact with reality, frequently felt compelled to create something as a way of coping with their confusion **(A)**. Sculptures of bread dough, and drawings on scraps of toilet paper **(B)** or walls, had long been noted in institutions housing the insane (cf. Prinzhorn, 1922).

Around the turn of the century, a few psychiatrists began to collect the spontaneous artwork of their patients. Although most "regarded them only as curiosities" (Plokker, 1965, p. 83), there were some notable exceptions. Paul-Max Simon, a French psychiatrist, published the first serious studies of the drawings of the mentally ill (1876, 1888). He was joined by Cesare Lombroso (1887), whose linking of genius with insanity is still being debated today. In 1901 a French psychiatrist named Reja wrote about the art of the mentally ill, noting three types. These early workers appreciated, even before the advent of depth psychology, that patients' products were related to their conflicts—that, as confusing as they often were, they made a kind of psychological sense.

With the arrival of psychoanalysis, those studying the mind began to find ways to unlock the puzzle of "primary process" (unconscious, illogical) thought (Freud, 1916–1917). They were thrilled to be able to decode the meanings of images, whether in dreams, reverie, or the art of the insane. In 1918 Paul Schilder, the psychiatrist who originated the concept of the "body image" (Schilder, 1950), published a monograph in which he compared art by one of his patients to the avant-garde work of the time. He suggested that while both seemed "mad" to the layman, they also made psychodynamic sense.

In 1921, a Swiss psychiatrist named Morgenthaler published a case study of Adolf Wolffli, a gifted paranoid schizophrenic artist **(C)**. The soil that nurtured expressionism and psychoanalysis was rich with the excitement of discovering buried treasure. In 1922 a Viennese art historian and psychiatrist named Hans Prinzhorn published the most extensive study ever of the art of the mentally ill (trans. 1972), and part of the collection toured the United States in 1985. The most recent survey of the topic is by art historian James MacGregor (1989).

Interdisciplinary Exchange

Interest in the *Psychopathology of Expression* has continued into the 21st century. For many years, psychiatrists, art historians, and art therapists from around the world have met regularly in an interdisciplinary organization. The International Society for Psychopathology of Expression (SIPE) was founded in Europe in 1959 and is still in existence. It is significant that because of the development of the profession this book is about, the organization has changed its name to the International Society for Psychopathology of Expression and Art Therapy (www.online-art-therapy.com).

The American Society for Psychopathology of Expression (ASPE) was founded by Irene Jakab **(DVD 3.6)**, a Hungarian psychologist and psychiatrist **(A)** who translated and updated her own groundbreaking 1956 book in 1998 **(B)**. One of the founders of SIPE in Verona, Jakab founded the American branch of the society in 1966. In addition to representing one of the interest areas leading to the emergence of art therapy, the meetings of the ASPE facilitated communication among art therapists in the United States, especially before there was a national association. In addition, the published *Proceedings* (under Jakab in the References) provided invaluable written resources for art therapists when literature in the field was still extremely scarce.

Another forum for interdisciplinary exchange was provided by Mary Perkins, an art teacher at the Dr. Franklin Perkins School for children with developmental disabilities. Perkins organized a series of meetings during the 1970s entitled "The Arts in Education International Seminar Series." In 1972, the topic was "Order and Discipline in Art as Models for Effective Human Behavior." As a participant, I had the pleasure of meeting many interesting people who had done groundbreaking work with youngsters who had disabilities, emotional as well as physical and cognitive.

One of them was my roommate, a pioneer British art therapist named Diana Halliday **(C)** (cf. Dalley, Halliday, Case, & Schaverien, 1987). In her presentation, Halliday quoted her mentor, Professor Carstairs, whose words are apt for this chapter on history: "Art expression is as old as Paleolithic man, and as young as psychedelics. It has been the medium for profound explicit commentaries on the state of the world, on the nature of man, and also for the relatively formless emotional outpourings of lyricism—or of torment."

A similarly fruitful interdisciplinary dialogue was facilitated through a series of symposia and publications in the 1980s about *Psychoanalytic Perspectives on Art*. The meetings were organized by a team that included analyst John Gedo (1983), art therapist Laurie Wilson (2003), and art historian Mary Gedo (1985, 1987, 1988).

Creativity and Madness

Another interdisciplinary series of conferences, all held in artistically rich settings, have been sponsored since 1983 by the American Institute of Medical Education. The meetings, occurring several times a year, were first organized by a multidisciplinary group that included a psychiatrist, an internist, an artist, and an art therapist, Evelyn Virshup (1978, 1993). The same group also edited a book, *Creativity & Madness: Psychological Studies of Art & Artists* (Panter et al., 1995) that was an outgrowth of those meetings.

Studies of the psychopathology of expression are intimately related to the ongoing debate about the relationship between creativity and madness. The nature of the connection is, of course, relevant for art therapy. It is now known statistically, as well as anecdotally, that the incidence of bipolar (manic-depressive) disorder is significantly greater among creative artists than in the population at large (Jamison, 1993). It is also known that some individuals are more productive during episodes of illness, while the creative output of others suffers in both quantity and quality. Did Van Gogh and Munch paint *because of* or *in spite of* their ailments? The question is a complex one at best, and there is as yet no clear consensus.

What is less debatable and more relevant is that people suffering from acute mental distress are often better able to express themselves through the more direct language of paint, clay, or pastels. When the verbal mode is absent (as in catatonia or mutism), or so confused as to be largely indecipherable (as in the "word salad" and neologisms of some psychotic states), "image-talk" can be a vital form of communication and a welcome release of tension. Psychotic imagery is sometimes childish, primitive, and confused, but it can also be very beautiful. Its aesthetic appeal is probably more significant than its symbolic meaning in its persistent popularity.

Art Brut and Outsider Art

Since the turn of the century, artists and art critics have been intrigued with the art of untutored individuals, including the spontaneous and lively work of young children. The French Impressionists were fascinated by the creations of primitive tribes and exotic cultures. Many artists and critics have valued work by those with no formal training—called "naive" or "primitive"—from the Frenchman Henri Rousseau to the American Grandma Moses **(DVD 3.7)**.

In the late 1940s, painter Jean Dubuffet was drawn to what he named Art Brut (Thevoz, 1976) **(A)**. This is a broad characterization covering all kinds of "raw" creations, including artwork by those with mental illness. Also called Outsider Art **(B)** (Cardinal, 1972; Hall & Metcalf, 1994; Trechsel, 1995; Yelen, 1995), both terms capture the sense of alienation associated with untamed expressions of the human spirit, whether by indigenous peoples, children, naive adults **(C)**, or those with psychiatric disorders.

Art in Diagnosis and Therapy

A similar vein fertilizing the soil for the eventual emergence of the field of art therapy was the growth of projective testing in the field of clinical psychology **(DVD 3.8)**. Finger paint, from the time of its invention by teacher Ruth Shaw (1938) in 1931, was thought to be potentially diagnostic as well as therapeutic and was used in many treatment centers, including the Menninger Clinic **(A)**. My own first exposure to the idea that art could show something significant about people was in a 1954 child psychology class, where my teacher, Thelma Alper, shared her discovery that children from different socioeconomic milieus did very different kinds of finger paintings. When she held up the pictures, her excitement was contagious.

Figure 3.1 Joseph Berke, M.D. with artist Mary Barnes.

In addition to being attracted to the use of art for the purpose of *assessment*, it was natural that analytically trained clinicians of all sorts would be drawn to employ it as a means of *psychotherapy*. In fact, almost all of the references I found on the psychology of children's art for a 1957 seminar (with the exception of those by art therapy pioneer Margaret Naumburg) had been written by psychologists or psychiatrists. One was Ernest Harms, who first published in English in 1939, later founding the journal Art Psychotherapy in 1973. There were also papers by the team of psychologist Ernest Zierer and his artist wife Edith **(B)**, who began using what they called "creative analysis" at Hillside Hospital in 1943.

Several responsive therapists, whose psychotic patients began to spontaneously communicate through art, encouraged them to do so and utilized it as part of the treatment. There were many such clinicians, including Marguerite Sechehaye (1951) in France, Ralph Pickford (1967) in Scotland, Marion Milner (1969) **(C)**, Joseph Berke in England **(Figure 3.1)** (**D**), (Barnes & Berke, 1971; cf. also Barnes & Scott, 1989); Ainslie Meares (1957, 1958, 1960) in Australia, Ingrid Naevestad (1979) in Norway, and Sigrid Ude-Pestel (1977) in Germany. Their case studies demonstrate how their capacity to "hear" their patients' "symbolic speech" was crucial to their eventual success.

Therapeutic Art Education

While these developments were occurring in mental health, educators were discovering the value of a freer approach to art in schools. Inspired by Froebel's "kindergarten" in Germany

and Montessori's "infant schools" in Italy, many were persuaded that children needed to learn in more direct, personally involving ways. Those in *progressive education* were especially convinced that creative experiences in art were vital to healthy emotional development.

Early art education had been rigidly didactic, involving the copying of "good" art and the learning of basic principles of color and design. With the growth of the *child study movement*, along with the emphasis of psychoanalysis on the dangers of repression and the virtues of expression, things began to change. In Vienna an art teacher named Franz Cizek, who coined the term *Child Art*, encouraged children to paint and draw in a natural fashion, which was then a radical idea (Viola, 1942).

There was another Viennese who observed Cizek's methods, and who was especially sensitive to the value of personal expression in helping children to achieve what he called "self-identification." He was also exposed to psychoanalytic ideas during the formative years of his career, and was taught by Oskar Kokoschka, an Expressionist painter. Because he wrote a textbook in 1947 that has been used to train art teachers for 60 years, Viktor Lowenfeld had a profound influence on art education in the United States and on art therapy as well **(DVD 3.9)**.

Since his early work had been with blind and partially sighted children (Lowenfeld, 1939, rev. 1952) **(A)**, Lowenfeld was attuned to the perceptual and emotional impact of a disability on a child's self-concept **(Figure 3.2).** In a chapter (Lowenfeld, 1957) omitted from later editions of *Creative & Mental Growth* after his untimely death (Lowenfeld & Brittain, 1987), he described what he called an "art education therapy" for children with various disabilities.

Figure 3.2 Viktor Lowenfeld, Art Education Therapist.

Figure 3.3 Florence Cane teaching a student.

Although he made it clear that he was not advocating that teachers do counseling, Lowenfeld himself was briefly employed as an "art therapist" at institutions for the blind and the retarded in 1938 and 1939 **(B)**. Thanks to a student who recorded his lectures and a colleague who transcribed and published them, the warmth, brilliance, and humanity of Lowenfeld shine through perhaps more directly than in his books (Michael, 1982) **(C)**.

Lowenfeld was not alone in championing the psychological value of spontaneous expressive art for children. In England, freer art teaching was being advocated by Herbert Read (1958) and others. One was Maria Petrie, an art teacher who like Lowenfeld had fled Nazi Europe. In Part III of her book, *Art & Regeneration* (Petrie, 1946), entitled "Art & Therapy" Petrie described how art could help those suffering from physical, sensory, mental, medical, and societal ills.

In the United States another refugee, Henry Schaeffer-Simmern (1961), described his "experiments" in teaching art to several atypical groups, including individuals who were developmentally delayed and others who were incarcerated (Cf. Sarason, 1990). In New York City, Florence Cane **(Figure 3.3)**, an art teacher to whom psychiatrists referred patients **(D)**, wrote a book about her methods **(E)** for evoking creativity and promoting healing, which she called *The Artist in Each of Us* (1951).

Artists in Hospitals

The history of art in psychiatric settings is almost as old as the units themselves.

Figure 3.4 Georgette Seabrooke (Powell)—WPA artist.

As early as 1907, a teacher of clay modeling was working at Massachusetts General Hospital. And in 1929, William Alanson White, superintendent of St. Elizabeth's Hospital in Washington, DC, presented a paper titled "The Language of the Psychoses" with many references to patient art.

From 1935 to 1943, one of President Roosevelt's New Deal agencies, the Works Progress Administration (WPA), employed out-of-work artists in the Federal Art Project **(DVD 3.10)**. A young artist **(A)** who was to become an art therapy pioneer **(B)**, Georgette Seabrooke [Powell], was one of those who made murals **(C)** in Harlem Hospital through the WPA **(Figure 3.4)**. Through this avenue, in addition to painting murals in public buildings, many art teachers were enabled to offer classes during the 1930s to psychiatric patients in various settings, such as Bellevue Hospital in New York City (Bender, 1952).

By the 1940s the ground had been prepared, as it were, for the planting and budding of the discipline of art therapy. Most of the early work on the psychopathology of expression had been done by European psychiatrists. However, the same political situation that drove Petrie to England and Lowenfeld to America richly fertilized the soil in the United States, largely due to the influx of analysts and of the psychodynamic thinking that permeated both American education and psychiatry for many years.

Art Therapy Is Born

Naumburg and Kramer

Two remarkable women were primarily responsible for the planting, tending, budding, and blossoming of the American art therapy garden. Their contributions were distinguished not only by their pioneering work, but also by their articulate prose, which defined the new field **(DVD 3.11)**. Both Margaret Naumburg **(A)** and Edith Kramer **(B)**

Figure 3.5 Margaret Naumburg as a young woman.

were sophisticated in their reading and understanding of analytic theory, child development, art, and education.

They were unusually well qualified to synthesize these understandings into a theoretical basis for the newly emerging discipline of art therapy. And both were scholars, exploring other domains like archeology and ethology, to deepen their understanding of art therapy. Each of them was also extremely independent—as a person and as a thinker.

Although both relied on psychoanalytic theory, their definitions of art therapy were quite different, one stressing the *therapy* and the other the *art*. Naumburg **(Figure 3.5)** saw art as a form of *symbolic speech*, coming from the unconscious like dreams, to be evoked in a spontaneous way and to be understood through free association, always respecting the artist's own interpretations. Art was thus conceived as a "royal road" to unconscious symbolic contents, a means of both diagnosis and therapy, requiring verbalization and insight as well as art expression. Kramer, on the other hand, saw art as a "royal road" to *sublimation*, a way of integrating conflicting feelings and impulses in an aesthetically satisfying form, helping the ego to synthesize via the creative process itself.

Margaret Naumburg was also influenced by her sister Florence Cane (1951), the analytically oriented art teacher mentioned earlier. Naumburg herself was a pioneer in education as well as in art therapy **(C)**. She founded the Walden School in 1914 explicitly based on psychoanalytic principles, which, like the discipline she mothered, is still alive and well in New York City (Naumburg, 1928).

A remarkable woman, she had studied with pioneer educators John Dewey and Maria Montessori. Naumburg had also been so impressed by the infant field of psychoanalysis that she had been analyzed by both a Freudian and a Jungian, using her own art as part of the treatment process. Convinced that understanding oneself was essential in order to liberate children's creativity, Naumburg urged that all of the teachers at Walden be psychoanalyzed (Naumburg, 1928). For several years, beginning in 1920, the art teacher at Walden was Florence (Naumburg) Cane (1951).

Margaret Naumburg had the good fortune, as did several other early art therapists, to meet a psychiatrist who already felt that art could be a useful tool in both assessment and therapy.

Figure 3.6 Margaret Naumburg as a mature woman.

Dr. Nolan D.C. Lewis had in fact published two papers himself in the 1920s on the use of art in psychoanalytic treatment. As director, he was able to open the doors of the New York State Psychiatric Institute to Naumburg from 1941 to 1947, during which time she worked with individuals using art, and published a series of case studies in psychological journals **(D)**.

Naumburg then collected her child case studies and was able to publish them in a monograph that reached psychiatrists and psychologists. (Naumburg, 1947) She was intent on presenting her research as scholarly, since she wanted art therapy to be taken seriously **(Figure 3.6)**. Naumburg remained a tireless ambassador for art therapy throughout her life, lecturing far and wide in order to acquaint other professionals with this new field **(E)**. She published three more books (1950, 1953, 1966), as well as many book chapters and catalogs for exhibitions of patient art.

Naumburg was something of a rebel, no doubt an essential quality for anyone choosing to challenge the establishment. In her theory too, she was unusually eclectic for the period. Having experienced both a Jungian and a Freudian analysis, she saw values in each that were relevant for the use of art in therapy. She was also open-minded about the meaning of visual symbols, choosing to rely primarily on the artist's own associations.

The other most influential writer and theorist was Edith Kramer. An artist who fled Prague just before the Second World War, Kramer had been exposed to a rich diet of psychoanalytic thinking, as well as to Lowenfeld's ideas about art education **(F)**. Having already seen the value of art for the refugee children she taught before leaving Europe, Kramer was ripe for a job in 1951 as an art therapist at Wiltwyck, a residential school for disturbed children in New York **(Figure 3.7)**, obtained with the help of an analyst from Europe, child psychiatrist Viola Bernard. Her first book, *Art Therapy in a Children's Community* (Kramer, 1958), was inspired by this work **(G)**.

Kramer's thinking was different from that of Naumburg, whose theory of art therapy reflected the emphasis in early psychoanalysis on *making the unconscious conscious*. Kramer learned analytic theory in a milieu that stressed *ego psychology*. It is also relevant that Kramer's work was always as an *adjunctive therapist*, allowing her to freely concentrate on

Figure 3.7 Edith Kramer doing art therapy at Wiltwyck School.

the inherent healing properties of the creative process, whereas Naumburg's role increasingly became that of *primary clinician*. Kramer also contributed greatly to the literature, publishing two more books (1971, 1979), and many seminal articles, some of which have been collected in an edited volume of her writings (Kramer, 2000) **(H)**. Throughout her work, she stressed the primary role of art in the therapeutic process and the importance of continuing to create **(Figure 3.8)**.

Figure 3.8 A self-portrait by Edith Kramer.

Other Art Therapy Pioneers in the United States

Actually, one of the odd things about art therapy is that, since it was indeed an idea whose time had come, Naumburg and Kramer were not the only American pioneers. In fact, as art therapy came to be better known, many individuals in different places appear to have given birth to remarkably similar ideas around the same time, often unknown to one another. In other words, it seemed—after there was better communication—that there were quite a few people doing "art therapy," sometimes even calling it by the same name **(DVD 3.12)**.

Often there was another individual, one who already had recognized credentials, who opened or widened the door for the neophyte art therapist. Elinor Ulman **(A)**, for example, had a friend in artist/psychologist Bernard Levy, with whom she worked at DC General Hospital during the 1950s (**B).** He helped her start the first journal in the field, as well as an early training program at George Washington University, where he was Chairman of the Psychology Department. The three East Coast pioneers were well known, primarily because Naumburg and Kramer wrote the first books, and Ulman published seminal articles in the *Bulletin of Art Therapy*, some of which she later collected in two edited books (Ulman & Dachinger, 1975; Ulman & Levy, 1981).

There were also other art therapy trailblazers who had toiled in the hinterlands for many years prior to finding one another. With the soil so fertile in the predominantly psychoanalytic world of mental health, and in the "progressive" domain of education, artists and teachers doing something therapeutic were to be found in the Midwest as well as in the East.

Although the Menninger Clinic was in the wide open prairie of Kansas, it was and remains one of the most sophisticated psychiatric treatment centers in the world (now located at Baylor University in Texas) **(C)**. Because of the vision of the founding family, it pioneered in all of the activity therapies. From 1935 to 1937, an artist named Mary Huntoon **(D)** was invited by Dr. Karl Menninger to offer classes in painting and drawing to psychiatric patients **(Figure 3.9)**. In 1946 Menninger asked Huntoon to organize one of the first art therapy studios in the United States, at the new Winter Veterans Administration Hospital, also in Topeka, Kansas.

Figure 3.9 Mary Huntoon painting at an easel.

Figure 3.10 Don Jones doing art therapy.

In 1951, art therapy at the Menninger Foundation began another phase with the arrival of Don Jones **(Figure 3.10)**, an artist who, as a conscientious objector, had worked in a psychiatric hospital during World War II **(E)**. Jones, who stayed at Menninger's for 15 years, later trained an artist named Robert Ault **(F)**, who was hired in 1960, and who subsequently trained Charles Anderson **(G)**, hired in 1968. Both Ault and Jones were on the steering committee that formed the American Art Therapy Association (AATA) after Jones had moved to Harding Hospital in Columbus, Ohio. Both also pioneered in developing some of the first clinical internship training programs.

There were many others in different places in this country, usually invited into a psychiatric setting by a psychiatrist or a psychologist, most often having a primary identity as an artist or educator. Many of these individuals, like Marge Howard **(H)** in Oklahoma or Elsie Muller **(I)** in Kansas, gathered with the East Coast pioneers and their students at meetings of the ASPE. This group was led by another psychiatric supporter of art therapy—Dr. Irene Jakab, noted earlier as one of the founders of SIPE in Italy in 1959; she has been president of the American branch since 1966 **(J)**.

In the nation's capital, yet another pioneer art therapist was learning her trade in prestigious institutions **(Figure 3.11)**. She was a sculptor from Poland named Hanna Kwiatkowska **(K)**, and she had the good fortune to work first (1955–1957) at St. Elizabeth's Hospital—which actually had had an "art therapist" since 1943 (Prentiss Taylor)—and then at the National Institutes of Mental Health (NIMH) (1958–1980). At NIMH, with the support of psychiatric colleagues doing seminal work in the new field of family therapy, she invented and developed family art therapy and family art evaluation.

Myra Levick **(Figure 3.12)**, who started the first graduate training program in art therapy at Hahnemann Medical College in 1967, was an artist who had applied for work with psychiatric patients at Hahnemann Hospital in Philadelphia **(L)**. She was mentored by the

Figure 3.11 Hanna Kwiatkowska, family art therapy.

Figure 3.12 Myra Levick, founder of the first training program.

unit's director, as well as by Dr. Paul Fink, a psychiatrist and psychoanalyst who became her ally and guide. Together, they started first undergraduate and then graduate-level training. They also got the national organization of art therapists underway by hosting a critical meeting in Philadelphia in 1968.

Levick (along with Ault, Jones, Ulman, and Felice Cohen **(M)** from Texas) was on the steering committee that incorporated the *American Art Therapy Association*, which was voted into being at a second meeting at the University of Louisville in 1969. As the first president of AATA, Levick presided in 1970 at its inaugural meeting, with 100 people

Figure 3.13 Margaret Naumburg, first honorary life member of the AATA.

(including myself) in attendance. The first Honorary Life Membership award (HLM) was presented to Margaret Naumburg **(N)**, widely acknowledged as the primary founder of the field of art therapy **(Figure 3.13)**. Additional information about the beginnings of art therapy in America can be found in *A History of Art Therapy in the United States* (Junge & Asawa, 1994) as well as in Randy Vick's excellent chapter in the *Handbook of Art Therapy* (Malchiodi, 2003).

*Art Therapy in Other Countries (***DVD 3.13***)*

If Naumburg is the "grandmother" of American art therapy, the most likely candidate for "grandfather" would be her British counterpart, an artist named Adrian Hill **(Figure 3.14)** who published two books, in 1945 and 1951. Hill **(A)** wrote that he had coined the term art therapy in 1942 to describe the value of doing his own painting while he was recovering from tuberculosis in a sanatorium. Invited to offer art to other convalescents, Hill was as enthusiastic and energetic a campaigner for art therapy in Great Britain as Naumburg was in the United States.

Although the story of art therapy in England is as long and varied as in the United States, the growth of the discipline has not been as extensive. Even though the British Association of Art Therapists was formed earlier (1964), its history (Edwards, 2004; Hogan, 2001; Waller, 1991) suggests that political and economic pressures complicated the development of both jobs and training programs. But there were supporters like psychiatrist E. Cunningham Dax (1953), who in 1946 hired artist Edward Adamson **(B)** (1984) to set up a studio at Netherne Hospital (**Figure 3.15).**

Another important promoter of the arts in Great Britain was H. Irene Champernowne, a Jungian analyst who, with her potter husband Gilbert, founded a residential treatment facility in which the arts were central **(C)**. Withymead, a creative therapeutic community, was operated from 1942 to 1967 (Stevens, 1986). At the same time, Adlerian "social clubs" were being run by Dr. Joshua Bierer in London, where pioneer British art therapist Rita Simon (1992, 1997, 2005) began her work in 1941. And Jungian art therapist E. M. Lyddiatt (1971) developed studios in many mental hospitals beginning in 1950 (cf. Thomson, 1989).

Figure 3.14 Adrian Hill, art therapy pioneer in the United Kingdom.

Figure 3.15 Edward Adamson in the art studio at Netherne Hospital.

Canadian art therapy also had its indigenous pioneers—like Marie Revai **(D)**, who was art therapist at the Allan Memorial Institute in Montreal; Louise Annett, who ran a sheltered workshop for developmentally challenged "craftsmen"; and psychiatrist Martin Fischer, who founded the Toronto Art Therapy Institute. Because of Canada's vast size, many worked for long periods in isolation, like Selwyn Dewdney, who was the art therapist at a psychiatric hospital in London, Ontario, from 1947 to 1972. He and his wife Irene, who joined him in 1956, published several papers during the 1960s in the *Bulletin of Art Therapy*, which are found in edited collections of important articles (Ulman & Dachinger, 1975; Ulman & Levy, 1981). Art therapy is currently alive and well in all regions of Canada, with associations and training programs in each area (Edwards, 2004).

While the growth of art therapy in other countries has been slower than in the United States, recent decades have seen the development of budding programs around the globe. In the Netherlands, *creative therapy* has been practiced since the 1950s, with formal training since 1980. It seems to be largely an *art as therapy* approach, in contrast to Finland, where psychoanalysts have supported its development as an *art psychotherapy* approach.

In Japan the founding fathers were psychiatrists, like Dr. Tokuda, who themselves had been working with art in therapy since the 1950s. However, despite the continuing dominance of psychiatrists in Japanese art therapy for many years, an International Conference on the Creative Arts Therapies, organized by Japanese art therapists in that country and living in the United States, was held in Tokyo in October of 2006, creating significant momentum. In addition to a 2008 publication in Japanese with edited papers from the conference,[1] there have been study groups in various parts of the country, and efforts to create training programs **(E)**.

It seems that even if the seeds were planted early in other countries, most have taken longer to germinate than in the United States. For example, in France the Association Française de Recherches et Applications des Techniques Artistiques en Pedagogie et Medicine was formed in 1974, yet it was not until 1988 that the Federation Française des Arts-Therapeutes was born.

Even before the computer revolutionized globalization via the Internet, two important vehicles for communication among art therapists around the world were created—one by an American practitioner who became aware of the need in her travels, and the other by a group of European educational institutions who wanted to support each other in training. In 1989 California art therapist Bobbi Stoll **(F)** created a much-needed structure by founding the International Networking Group of Art Therapists (ING/AT), which sponsors a newsletter with correspondents in almost every country around the globe (www.converse.edu/ingat).

The European Consortium for Arts Therapies Education (ECArTE) formed in 1991 has held international conferences every other year in different countries, and has published proceedings as well. The European Advisory Board of National Art Therapist Associations met for the first time in 1993 in Germany, with the goal of working "on the recognition of the different arts therapies professions." The British agreed to develop "a questionnaire to determine the current situation of art therapy in a given participating country." These developments are reminiscent of the early stages of information-gathering and organizing among art therapists in the United States, an impression confirmed during the last two conferences sponsored by ECArTE (cf. Waller, 1998).

Currently, communication is becoming possible with some societies formerly closed to the West. In Russia, a meeting of expressive therapists from the United States and Europe was held in 1993, and a conference on the arts in psychotherapy and other fields in 1995.

That year, a delegation of art therapists consulted with mental health colleagues in China, and in 1996 a similar group visited Indonesia.

These beginnings, reported in the first edition of this text, have multiplied exponentially since then, with many from other countries who have trained in the United States initiating programs and beginning to develop a literature by translating English books and by writing books of their own that include chapters by authors from various countries (Danneker, 2004; Hampe, 2007; Seki, 2007). Within the last year I have written an introduction to a Korean translation of this book, a chapter for a Japanese book, and a foreword to a Thai translation of Edith Kramer's most recent book (2000). I am sure many others are similarly involved.

Individuals are actively contributing to one another's literature (Brooke, 2006; Schaverien & Case, 2007; Spring, 2007), and a recent book about the history and nature of the creative arts therapies, while mainly about the United Kingdom, also takes into account developments in other English-speaking countries (Jones, 2005). What is impressive about all of this international networking is that Newsletters of the International Networking Group of Art Therapists list correspondents on every continent. Even more noteworthy is the rapidly growing number of art therapy associations and journals around the world. Art therapy is an idea that has indeed become global in a relatively short period of time since its first beginnings in the 1940s.

In addition to training initiated by indigenous groups, many Americans have taught courses abroad, many have instituted summer internships in other countries, and a number of educational institutions in the United States and Canada have established satellite programs in Europe and Israel. As noted earlier, art and other expressive therapies have expanded rapidly in the latter, due, I suspect, to a continuing state of fear and vigilance. Much of the development in art therapy abroad has been stimulated not only by man-made terrorist disasters, but also by environmental ones, like tsunamis in India **(G)**.

Since retirement from clinical practice ten years ago, I have had the pleasure of teaching art therapy on many continents. In Europe I have visited and presented in Sweden, Finland, Italy, Germany, Estonia, and Ireland. I have taught in Israel, where art therapists are found in every school and where the profession has developed rapidly. I have also taught in South Korea, where there are two strong professional associations and many training programs, some in art therapy and others in expressive therapies. Asian art therapy is growing very rapidly, with a strong national association and training program in Taiwan **(H)**, and recent developments in Japan, noted earlier. In Bangkok, as mentioned in the last chapter, the Asia Pacific Art Therapy Center has been founded, several seminars have been held **(I)**, and an international conference is planned for the year 2010 **(J)**.

In Brazil, which is a vast country, art therapy groups within it have formed a federation and are in the process of developing standards of training and practice. I was impressed by the sophistication of those I taught in both Rio de Janiero and São Paulo **(K)**. It has been thrilling to observe the rapid development of art therapy around the globe, which I have no doubt will continue.

Although the soil and atmosphere in different parts of the world naturally germinate a variety of art therapy plants, some sturdier than others, it seems clear that the discipline, at least for now, is here to stay. It is still growing in the United States, despite massive budget cutbacks and radical changes in human services. Since the places where art therapists work (and the work they do) have continued to proliferate, it would appear that continued growth is inevitable, at least in the foreseeable future.

Concluding Thoughts

Given the blossoming of art therapy all over the world, it seems fitting to close this chapter with a statement written two centuries ago by a German poet, novelist, and scientist, whose studies included an elaborate theory of color and the emotions. Johann Wolfgang von Goethe (1749–1832) has been admired by people as diverse as Rudolf Steiner, father of the spiritual philosophy of anthroposophy, and Sigmund Freud, rational father of the highly verbal theory of psychoanalysis. In *My Italian Journey*, published in 1787, Goethe wrote: "We ought to talk less and draw more. I, personally, should like to renounce speech altogether and, like organic nature, communicate everything I have to say in sketches."

I have no doubt that Goethe would have welcomed the development of art therapy.

Endnote

1. Seki, N. (Ed.). (2008). *Atarashii geijyutsu no nagare-creative arts*. Tokyo, Japan: Film Art Inc.

CHAPTER 4

The Basics

… the art therapist is a specialist
who combines the qualification of being a competent artist with
specialized skills in the field of psychotherapy and education.

Edith Kramer

Art therapists know about art, about therapy, and about the interface between the two—doing art therapy. In contrast to the broad range of theoretical perspectives on art therapy and the wide variety in ways of working, most art therapists agree on the basic skills and understandings necessary for effective work. In *The Art of Art Therapy* (Rubin, 1984), I described in detail what I think art therapists need to know about each of these areas. This chapter will outline the basic elements of art therapy, and then note some basic reasons why it is effective.

Although knowledge about art and therapy is essential, no amount of knowing leads to effective art therapy without two basic beliefs shared by all art therapists—first, in the healing power of art, and second, in the capacity of all to create with art media. Necessary personal qualifications include sensitivity to human needs and expressions, emotional stability, patience, flexibility, a sense of humor, a capacity for insight into psychological processes, and the ability to listen attentively, to observe keenly, and to develop a rapport with others.

The Art Part

Knowing Materials

Whether entering the field via art or some other avenue, art therapists are familiar with a wide variety of materials, tools, and processes **(DVD 4.1)**. These include the surfaces on which people work, like different types and weights of paper, as well as the tools used with different media, like various kinds of brushes or clay-modeling implements. They also include the basic media for drawing **(A)**, painting **(B)**, and modeling and constructing **(C)**.

Art therapists are familiar with the specific qualities and particular capacities of each type: pencils, pastels, crayons, markers, finger paints, water colors, tempera, acrylic, oil, clay, plasticine, wood, wire, and so forth. Since art therapists are also artists, they have had personal experience with different media and processes **(Figure 4.1)**. Such experience is the best way to get to know them, and to help others learn to use them in a comfortable way.

Figure 4.1 The art therapist as artist—Florence Cane.

For practical as well as psychological reasons, the materials used in art therapy tend to be simple and unstructured. Since art therapists value the importance of each individual's creativity, whatever is offered needs to allow for personal expression and definition. Even if limited in quantity, the materials in art therapy should be of good enough quality to be utilized energetically. Supplies and tools used in art therapy are also stored and cared for with respect.

Individual Differences Many considerations affect decisions about which materials are offered and how. Some are pragmatic, like budget and population, others are more personal. There are in fact differences of opinion within the field about how many different materials should be made available, seemingly unrelated to theoretical preference. At one end of the continuum are those who are convinced that a few expressive materials are sufficient for most circumstances. At the other end are those who believe in offering as many choices as possible. Most art therapists fall somewhere in between.

Anyone who reads widely in art therapy will note a great variety of opinions about the most desirable materials and processes. Sometimes preferences are explained as reasonable for a particular population, setting, or purpose. Although such variables are indeed relevant, there are also more subtle influences on an art therapist's choice of materials.

One of my mentors, a psychologist named Margaret McFarland, taught that a child will develop positive feelings about any materials or activities that are especially valued by his mother. Thus, a preschool teacher noticed that her pupils must have known how much she

liked easel painting, because there was so much activity in that corner when she led the group. Yet when the same children were taught by a woman whose interest was in modeling, there was a preponderance of clay work.

In a similar fashion, an individual art therapist's enthusiasm for a particular medium or process is likely to stimulate interest in it for those with whom she works. In after-school workshop groups at a child study center, I used to call this the Pied Piper Effect. If I wanted to get the youngsters to try any art activity, all I needed to do was to start doing it myself. They would usually come, look, and eventually become engaged.

As for media offerings, my own preference has been for a broad selection under most circumstances. This approach seems sensible to me, because I sincerely believe that any individual does best with materials that allow him or her to feel as comfortable as possible. I also trust, because of my experience with many different populations, that even those with poor ego boundaries tend to choose materials they can control. However, I know myself well enough to be aware that my need for people to have choices is not limited to my work in art therapy, but extends throughout my life, from menus to maps. So, like most, I have managed to justify making materials available to people in a way that is syntonic with my personality.

The processes of working with art materials are as varied as the media themselves. Art therapists, regardless of individual predilections, are familiar with a wide range of materials, tools, and ways of working. Most practitioners draw upon an extensive awareness of many different possibilities for creative work. The range of what can be used and how is limited only by the knowledge and creativity of the individual clinician.

Keeping Up with New Media Since the definition of art is continually expanding, offerings in art therapy are too. For example, recent technological developments have tremendous potential for all kinds of creative work. Because I cannot sit comfortably in a desk chair since having back surgery in 1989, the laptop computer on which I wrote and revised this book allowed me to type while sitting in a recliner. I used the same kind of arrangement to create the video clips on the **DVD** that is in the back of the book.

For me, a notebook computer is not only a welcome convenience; it actually makes continued creative work possible. For those who are severely disabled, a computer can be a critical prosthesis, which can be used to create pictorial images as well as words. For anyone wanting to animate artwork, the computer offers an exciting avenue. Art therapists are just beginning to plumb the possibilities of this technology as part of their work (Malchiodi, 2000).

New art materials and tools are continually being developed. These can be especially useful for particular expressive needs. Tempera markers **(D)**, for example, are perfect when a person wants to pound aggressively with paint, or to use paint in settings where there is a need to minimize the mess. The right materials can make possible the successful expression of visual ideas. Staying informed about these is as important as keeping up with professional literature, since knowing new media is as critical to doing art therapy as knowing new drugs is to practicing medicine.

Understanding/Analyzing Materials In 1978 two art therapists proposed a way of understanding and of classifying both materials and processes. The Expressive Therapies Continuum was the product of collaboration between Vija Lusebrink **(E)** and Sandra Kagin Graves **(F)**. It is based on Kagin's earlier work, in which she defined "media dimensions variables." The system itself is not used by everyone. But the kind of thinking it embodies—about the nature and properties of work with materials—is part of any competent art therapist's decision-making process (Lusebrink, 1990; Hinz, 2009).

Although materials are an essential component of our work, they have not been discussed by many authors, perhaps because we take them for granted. Edith Kramer noted the properties of different media in her 1979 book, to which Laurie Wilson **(G)** also contributed a section called "Pre-Art Materials." There was a brief chapter called "Art Materials" in Arthur Robbins's **(H)** first book (1980), and Helen Landgarten **(I)** (1981) described work with a resistant adult, focusing on her rationale for choosing both the media and the tasks. The "task analysis" approach can also be helpful in media selection (Wilkinson & Heater, 1979).

Knowing the Creative Process

Understanding and being able to facilitate a genuinely creative process are also parts of every art therapist's armamentarium **(J)**. While there are many individual differences in how each worker goes about accomplishing this, all agree on its importance. Like being familiar with media and tools, this is one of the ways in which art therapists differ significantly from other clinicians who use art materials in their work. Facilitation sometimes involves teaching—often of techniques, always of ways to express the self authentically **(Figure 4.2)**. As with knowing media, personal experience of the artistic process is critical in helping others to achieve the altered state of consciousness required for creating.

Equally central in effective art therapy is knowing how to observe another's creative process acutely, sensitively, and nonintrusively **(K)**. Becoming aware of all of the temporal, spatial, and other nonverbal aspects of people's behavior with materials takes time and practice **(Figure 4.3)**. It is a major component of training because the more an art therapist can see, the more she can figure out, and the more effectively she can intervene to help. As Robert Ault **(L)** once said, a picture may be "worth a thousand words," but "to observe the making of a picture is worth ten thousand words."

Figure 4.2 The art therapist as teacher—Gladys Agell.

Figure 4.3 Observing the process—art therapy student.

Knowing Artistic Products

As with the other elements of "the art part," there is essential agreement about the centrality of the product, along with a variety of opinions about its place in art therapy. Although the person being served is always more important than either product or process in art therapy, the very existence of a concrete product makes art therapy unique.

In addition to helping the artist to see himself in a new way, creative products often enable others on the treatment team to understand a patient better. They can also be useful with family members and other clients. They are a silent but eloquent form of education, whether displayed in the treatment setting or at a gallery. And at the end of the therapy, art products offer a vivid way for participants to review—to relive and to assess what happened during the therapeutic journey.

Those who emphasize the art in art therapy are more likely to view the quality of the product as related to the success of the therapy. This group includes those who espouse an art as therapy approach, as well as those who find special value in the image, and who come from a wide variety of theoretical orientations.

Those who emphasize the therapy in art therapy are less likely to be concerned with quality, and more likely to focus on the communicative value of the artistic product. They too are interested in the image, but primarily for what it says rather than how well it speaks. Janie Rhyne **(M)** (1995), who studied line drawings of feeling-states based on George Kelly's "personal construct" theory, described such creations as "visual languaging."

All art therapists value authentically expressive work, whether crude and primitive or sophisticated and refined. This is true regardless of whether they stress art or therapy in how they define the work. Margaret Naumburg, for example, though she wrote primarily about the value of art as "symbolic speech" emanating from the unconscious, encouraged and valued powerful visual products. This is apparent in the vivid images she selected to illustrate the case studies in each of her four books.

In all art products, there are two elements that can be identified and understood—form and content. Some art therapists focus more on one or the other; most value the importance

of both. Edith Zierer sometimes had students view patient art upside down, so they could focus on the formal element of "color integration" undistracted by either content or competence. Rita Simon's (1992, 1997, 2005) approach to art therapy emphasized style. And in Janie Rhyne's (1995) "personal construct drawings," the form itself became the content of the communication.

The subject matter is significant too, and like the manifest content of a dream, may be disguised. Understanding the nature of metaphor and symbolic expression is, therefore, critical to any translation of artistic meaning. A literate understanding of the language of both form and content is vital to an art therapist's functioning. The complex intertwining of these two variables constitutes the grammar of art, which must be mastered by art therapists in order to develop visual literacy in their work.

Clinically sophisticated vision can decipher artistic information about development, about psychodynamics, and about psychopathology. Art therapists learn to "listen" to what art products have to "say." While there are many different ways to look at or to think about art, doing so sensitively and coherently is central to conducting effective art therapy.

Understanding the art part of art therapy, then, involves knowing a great deal about materials, the creative process, and artistic products. As with media and processes, most art therapists are highly respectful of the products created therein. Whether and where they are displayed or stored depends on many variables (cf. Spaniol, 1990), but they are always handled by art therapists with the utmost care. Since artistic products are also statements by the individual—whether garbled or articulate—they are treated with the same confidentiality accorded verbal communication.

The Therapy Part

Knowing Development

The second major component of art therapy is the therapy part. Whatever preferred theoretical orientation they eventually adopt, all art therapists have some basic frame of reference about human psychology. They need to have a clear picture of normal development, in order to identify deviations therefrom. In addition to knowing something about cognitive, emotional, and social growth, art therapists are familiar with normal development in art. Art therapists are also informed about a variety of developmental perspectives, so they can selectively choose and/or synthesize their own.

There have been a great many studies of late, often using advanced imaging techniques, and especially in the area of attachment and neurobiology (Siegel, 1999). The hopeful part of this is that it looks like there is a good neurological reason why therapy works (Solomon & Siegel, 2003) and particularly why nonverbal therapy is effective (Arrington, 2007).

Knowing Psychodynamics

In a similar fashion, art therapists understand psychodynamics, both within and between individuals. Whether they are partial to a conflict or a deficit theory of psychopathology, art therapists are familiar with both ways of thinking. Art therapists are also knowledgeable about different understandings of both intrapsychic (Freud, 1916–1917, 1923) and interpersonal dynamics. The latter includes dyadic (two-person), triadic (three-person), and group (Yalom & Leszcz, 2005).

Knowing Pathology and Potential

Like other clinicians, art therapists are familiar with the major theories of personality and psychological functioning. All therapists need to have some coherent way of thinking about what is wrong (pathology) and what is right (strengths) so they can figure out how best to help (therapy). Eventually, most practicing clinicians choose to deepen their understanding of one preferred frame of reference, so that theory becomes well integrated with technique.

Because psychopathology has been defined descriptively as well as etiologically, art therapists are trained to understand the meaning of the current diagnostic classifications. The specific languages individual art therapists utilize depend mainly on where they work. For example, those who are in psychiatric settings understand the thinking behind systems like ICD-10 (World Health Organization [WHO], 1992) and DSM-IV TR (American Psychiatric Association [APA], 2000), the most widely used forms of classification. Similarly, those in special education and rehabilitation are familiar with current categories in the classification of disabilities.

Knowing Treatment Planning

In addition to knowing the terms used to define different diagnostic groups in human service settings, art therapists are also familiar with the various languages used to describe the process of helping. Whether writing a treatment plan in a psychiatric hospital or an IEP (individualized educational plan) in a school, art therapists are multilingual, though fluency in any one language develops through usage. Regardless of the setting, competent art therapists understand ways of describing what is wrong, planning to help, and evaluating the effectiveness of their intervention (cf. Frostig & Essex, 1998).

*Knowing the Therapeutic Dyad (***DVD 4.2***)*

Another core area of understanding about therapy has to do with the importance and meaning of the relationship with those who are served. Whether or not an art therapist fosters or utilizes the symbolic aspects known as transference, all schools of thought about helping people to change recognize the significance of the climate between clinician and client. Art therapists are usually encouraged—and sometimes required—to get to know themselves better through their own psychotherapy. This is essential, so that their own issues do not interfere with their ability to use themselves in their work with other people.

Many outcome studies, involving a wide range of theories and techniques, have found the most critical variable in the therapeutic equation to be the fit between patient and clinician. Art therapists of all theoretical stripes agree on the importance of the therapeutic alliance. Freud once suggested that this critical relationship provides the "anesthetic" that makes possible the sometimes-painful "surgery" of an interpretation. Alliance in psychotherapy means trust and commitment, not social or physical intimacy. Ethics committees in service disciplines report that most patient complaints involve what are known as boundary violations, the dark side of the immense power in the relationship itself.

Although some argue that art therapy dilutes the intensity of the transference—because of the more active teaching component in the therapist's role and the existence of the art object as an intermediary—I do not agree. In fact, it appears to me that art therapists, because we draw on and expose the innermost private parts of the human soul, often have an even more "intimate" relationship with our clients than talk therapists. And, since a great deal of physical activity (with materials, tools, products) is a necessary component of

the work, we may have increased potential to do harm as well as to heal. In any case, knowing the importance, meaning, and power of the relationship—both real and symbolic—is basic to being a responsible art therapist.

Knowing the Process of Change in Therapy

Equally basic to comprehending the therapy part of the work is having some understanding of the process of change. Although there is such a thing as one-trial learning, most psychological therapies take time and go through stages. This is true whether the treatment is short term or long term, and whether it is open ended or time limited. There are many variations, depending on multiple factors, but art therapists, like other clinicians, need to have a sense of the shape of the therapeutic process over time.

As with theories and techniques, clinicians often disagree about the names or the nature of the sequential stages or phases in treatment. However, most agree that they occur and that they are, in a general way, predictable. There is always a beginning, a middle, and an end, and the worker needs to understand the goals and interventions appropriate to each phase. Otherwise, doing art therapy would be like flying blind, a situation unlikely to induce security in either the pilot or the passenger(s).

Necessary Conditions: The Framework

Understanding therapy is as central for an art therapist as knowing art. In order to facilitate authentic expression, the clinician needs to create what I have called a framework for freedom (Rubin, 2005b). The conditions necessary for effective art therapy tend to cut across theoretical and stylistic preferences. Because of the concrete nature of the modality, they are physical as well as psychological. Although it is rare that an art therapist finds or creates a perfect set of conditions for her work, some are fundamental. Political as well as psychological, they are closely intertwined.

A Supportive Setting

For example, before an art therapy program can take place in any kind of setting, somebody needs to be convinced of its desirability. Depending on the chain of command among the person(s) with the power to decide and those who implement, the support can vary. If those choosing art therapy are able to facilitate positive attitudes in other staff members, achieving good conditions becomes a feasible goal.

However, it is not uncommon for a busy administrator to hire an art therapist, who arrives only to discover that she is viewed suspiciously by her co-workers, sometimes even by her supervisor. Indeed, one of the intra-institutional hazards faced by art therapists is the possibility of envy from their co-workers, for the very reason that those receiving services are frequently more willing to go to art therapy than to other less pleasurable activities.

In order to establish the basic conditions necessary for good art therapy, it is necessary to have support within the setting from both administrators and colleagues. This requires preparatory and ongoing education of the person responsible for overseeing the art therapy program, who needs to understand just what its value can be in that particular setting. If he or she is well informed and can educate others, the potential for effective work is greatly enhanced. It is not sufficient to simply create an art therapy position or program in any setting. Whether brand new or established, solid support for the physical and psychological conditions needed for good art therapy must also be present. As with any partnership, maintaining the alliance is essential.

This means that part of any art therapist's job is to be active in gathering support within the working environment. When I began work at the Pittsburgh Child Guidance Center, I offered to give a presentation at a clinicwide staff meeting about art therapy, where I was able to invite requests from others for consultation, collaboration, and research. Meetings with the heads of each department within the center were also fruitful and led to in-service training for the psychiatrists, psychologists, and social workers who worked and who were training there. These initial presentations and meetings also led to a series of research investigations, as well as the development of a family art evaluation and conducting co-therapy with a number of colleagues from different disciplines (Rubin, 2005a, 2005b). On the **DVD (4.3)**, you see my colleague, the gentleman with blond hair in the upper left of the picture, observing a child in a family art evaluation **(A)** that he and I created and conducted. His support for art therapy as Chair of Psychology at the Pittsburgh Child Guidance Center was extremely helpful.

Collaborating with colleagues is probably the most effective way of gaining support and is enriching for all participants. On the **DVD** you can listen to Irene Rosner-David describe how it is done at Bellevue Hospital, where she is the director of the Creative Arts Therapy Department **(B)**. You can also watch Roger Arguile meeting with other staff in his work at a school for exceptional children **(C)**, and see Ellen Horovitz collaborating with a speech therapist on one boy's treatment **(D)**.

Support for the art therapist's work needs not only to be requested but also nurtured. Only then is it possible to create conditions that are as good as possible under the circumstances. Art therapists learn to be flexible about the fact that optimal conditions are rare. Knowing what would be ideal, however, helps an art therapist to maximize the potential of any particular situation, and to work toward improving it. It is similar to having a model of a mentally healthy person in mind, while helping each patient to come as close as he or she can.

Physical Conditions

An ideal physical setting for art therapy is private and protected from intrusion, has adequate light and working surfaces, contains within it an easily accessible water source, and has sufficient space for storage and display of art supplies and products. In the best of all possible worlds, it does not need to be shared or used by anyone else.

While it would be lovely if all could operate under such conditions, that is rarely the case. More often, the art therapist must access her own considerable creativity in order to make the best of a less-than-ideal situation. Although art therapists are usually required to accommodate to the setting and its deficits, a clear understanding of the importance of a safe and secure physical framework helps in obtaining both administrative and staff support. Being willing to help others in their work in whatever fashion they request pays off handsomely when it comes to getting and maintaining the necessary conditions for creative work.

Psychological Conditions

It could be argued that a safe and secure psychological framework for all therapy, including art therapy, is even more critical than a physical one. It is probably that which accounts for the remarkable fact that powerful art therapy can take place in suboptimal situations, like a patient's bedside on a crowded hospital ward, or the corner of a hectic shelter for battered women. "Art is a quiet place," even in a noisy room or in June's cage at the zoo (cf. Chapter 3).

Despite the possibility of conducting art therapy under difficult circumstances, a stable set of physical and psychological conditions is still best. This requires the same kind of

steadiness and predictability from an art therapist as from a talk therapist. What is added is a need for clarity and consistency in offering materials, evoking their use, facilitating expression, and dealing with artistic products. Creating an environment in which people can feel metaphorically *held* and secure is as much an art as a science, regardless of the actual setting.

This is something with which art therapists are especially concerned, because of the particular requirements of a place where authentic creative work is really possible. As with other aspects of clinical style, individuals find their own way to make even the most unlikely setting workable and inviting. Most art therapists work hard to create a peaceful and protected atmosphere, one where the spirit can safely soar.

Time and frequency are also important elements of the framework. Many kinds of art activities need adequate time as well as sufficient space, and some require continuity. While compromises are often necessary, the art therapist's understanding of the importance of all aspects of the physical and psychological framework is vital to her ultimate success.

Doing Art Therapy: The Interface

Armed with a solid understanding of both art and therapy, each of which is outlined above, the clinician is then prepared to put them together in the conduct of art therapy itself. As noted earlier, it is the interface between art and therapy that is the essence of the work. The chapters in the "Interface" section of *The Art of Art Therapy* (Rubin, 1984) deal with the need to accomplish a series of tasks in steps that include: setting the stage, evoking expression, facilitating expression, and looking at and learning from the art and the experience of creating (**DVD 4.4**).

Setting the Stage

The first task is to set the stage, in both larger and smaller arenas, as noted in the discussion of the necessary conditions for effective therapy. Art therapists are usually quite skilled in creating a studio/working space that is both orderly and inviting (cf. C. H. Moon, 2002; Jones, 2005). Doing these well requires artistry as well as knowledge. A prepared environment, however, is just the beginning.

Evoking and Facilitating Expression

Art therapists work hard and thoughtfully at evoking expression. Stimulating often-resistant individuals to work creatively with materials requires skill and inventiveness. The way in which people are invited to work is complex, since there are many possible variations on materials, tasks, and ways of working. On the **DVD** you can watch child psychiatrist Robert Coles inviting a child to draw his uncle who has been shot and about whom the boy has been talking **(A)**. You can also watch me inviting members to make a family representation **(B)**.

Once people have gotten started, the art therapist's job is to make sure they can work with the utmost freedom and success, while carefully observing each step in the process. There is an art to facilitating expression in a way that honors each person's creativity, yet provides assistance when needed. On the **DVD** you can observe Vera Zilzer watching the sequence of items drawn by Robert, a man with schizophrenia **(C)**.

Looking at and Learning from the Art Process

One of the ways in which art therapy differs from other therapeutic uses of art is the frequency with which the clinician helps the patient to learn from the experience as well as

Figure 4.4 Learning from the art product—Sandra Kagin.

the product. In addition to observing the creative process in order to learn more about the person doing the work, art therapists help patients reflect on how it felt to use the materials or to express the ideas and feelings involved. On the **DVD** you can observe Natalie Rogers helping Robin, a young woman, to compare her two drawings **(D)**.

Looking at and learning from art require skills that are highly developed among art therapists. Art teachers know how to critique products in order to help students to improve, and art historians know how to look at artwork in order to understand a style, period, or artist. But those ways of looking at and learning from art are quite different from those that are crucial in art therapy **(Figure 4.4)**.

The challenge facing art therapists is to find the best way to help each artist understand him- or herself by relating meaningfully to what has been created. This can happen nonverbally, through gazing at or moving to the image, as well as verbally by talking or writing about it. Indeed, both can occur in a number of different ways—a constant creative challenge. On the **DVD** you can observe dance therapist Carolyn Grant Fay's client moving in response to a drawing she has already made and discussed **(E)**.

Working Artistically

Art therapists have a wide variety of approaches to all of the steps noted above, determined by personality as well as by theory. There are individual differences in every area of actual practice, from setting the stage to evoking and facilitating expression, to looking at and

learning from the art that has been produced. Most art therapists, regardless of personal style, see themselves as working artistically.

A principle that makes sense to me is to intervene—at all stages of the process—in the least restrictive and most facilitating fashion. Although this may sound simple, it is a highly developed skill, best refined through practice. While relevant for all therapists, it is especially important in the specialized work of doing therapy through making and learning from art.

Basic Principles

Sometimes art therapists do things that do not involve patients or clients, such as teaching, supervision, consultation, and research. The fundamental principles in each are identical to those for direct service, and follow the same sort of sequence. For example, it always helps to begin with some kind of assessment of the current situation. That means finding out where a patient is for therapy, where a student is for teaching or supervision, and where an institution or individual is for consultation. When doing research, it is important to know what has been done before by reviewing the literature.

After assessing a situation by gathering relevant data, the next step is to set reasonable goals, and to decide how to proceed in order to achieve them. It is also necessary to form a respectful alliance with those being served, so that the work is truly cooperative, whether it is doing therapy, teaching, supervising, consulting, or conducting research. Ultimately, it is also necessary to evaluate whether the goals have been met.

Selecting Art Therapy

When I was first invited to start a pilot program at the Pittsburgh Child Guidance Center, my supervisor, Dr. Shapiro, asked me to find out how to select patients for art therapy. In March of 1969, I went to New York with a list of questions for all the experienced art therapists I interviewed. These included psychologist supporters of the field, like Ernest Harms and Ionel Rapaport, and pioneer art therapists, like Edith Zierer, Edith Kramer, and Margaret Naumburg. All of them agreed that the question of the "treatment of choice" was a complicated one about which very little was known, especially in regard to the new discipline of art therapy.

One suggestion was to do an art interview as part of the intake for everyone, and see how they responded. Another suggestion was to ask clients whether or not they would like to have art therapy. The beginnings of art therapy stemmed in part from spontaneous art by the mentally ill, certainly a self-selection process. And in the early days of the field, some artist-therapists traveled the wards, offering art supplies and assistance to whoever was interested—like Adrian Hill in England or Prentiss Taylor at St. Elizabeth's Hospital in the United States.

Sometimes there was an open studio in a psychiatric hospital, where patients could come and use art materials on a voluntary basis, like those of Edward Adamson or Mary Huntoon. Although contemporary art therapists work in settings where people are generally referred for treatment, it is also common to offer open groups as well, especially in long-term settings. People in private practice often get clients who have decided to come, specifically because they want to be treated by an art therapist. But that reminds us of a larger question: Since resources of people and money are limited, why use art therapy as opposed to some other kind of intervention? And how can we evaluate whether or not our efforts to help through art have been effective?

Assessment in Planning and Evaluation

Like all responsible clinicians, art therapists routinely assess whether what they are doing is working. There is an increasing demand for proof that what is being done is having an effect, and has become the rule rather than the exception, as in "evidence-based" interventions (cf. Gilroy, 2006). Art therapists, therefore, need to define goals and to evaluate progress in a fashion that can be communicated to the others involved.

For example, an art therapist working with children who have disabilities in a school is able to articulate short-term objectives, long-term goals, ways of achieving them, and ways of measuring them. This is all part of a child's IEP, or individualized education plan (Bush, 1997; Frostig & Essex, 1998; Stepney, 2001). Treatment planning, as well as periodic evaluation, is also required in mental health settings, whether they are inpatient, partial, or outpatient. Setting specifically defined objectives and demonstrating that the art therapy intervention is working are central to the most recent development in mental health, managed care.

Evaluators, who often have the power to approve further art therapy, are most comfortable with behavioral objectives, whether they are in developmental, cognitive, emotional, or social domains. Art therapists therefore need to observe behavior during the creative process, measuring changes in such areas as autonomy, organization, and interaction with others. They also need to look at indices external to art therapy, like behaviors at home, in school, or at work, and symptom frequency. Rating scales by the patient or others (parents, teachers, staff) are sometimes used, as are objective measures like number of absences or level of performance (Bush, 1997; Frostig & Essex, 1998; Wadeson, 1992).

There are also general objectives that apply to all individuals with whom we work in art therapy. These include being able to set achievable goals, and feeling good about oneself and one's relationships. Whether the person's disability is temporary or permanent, a generally acceptable objective is to be able to make the most of personal and societal resources.

We all wish to free people to fulfill their potential, whatever that may be—to be able to live, love, work, and play to the fullest. All in the helping professions, including art therapists, share a wish that optimism will triumph over pessimism, and that hope will be victorious in the battle with despair. Achieving such goals may not be as simple to measure as reducing the frequency of hospital visits or increasing a person's capacity to concentrate, but they are central to being human and are the reason most of us choose to serve others.

As a matter of professional ethics, responsible art therapists continually evaluate their work. Of course, the big question is not so much whether the art changed (although that can serve as a useful index), but whether or not the person(s) changed in the way(s) you and they had hoped. There are important issues about societal norms regarding goals, some of which are especially relevant to art therapists.

In terms of planning and evaluation, goals and objectives cannot always be spelled out in advance and experienced art therapists are able to modify expectations as the work progresses. As with any creative process, you might have a general sense in advance of how it will turn out. But only when you fully, freely, and openly engage, can you discover how it's actually going to shape up, and what is required from you. This is true not only in creating art, but also in doing therapy, indeed for all kinds of service (teaching, consultation, supervision) as well.

Evaluating Art Therapy

All service professions are increasingly being asked to account for the effectiveness of what they do in "evidence-based" practice (Gilroy, 2006). When budgets need to be cut, whether

in society, education, or health care, both art and mental health are often viewed as "frills" or "luxuries." As already noted, the consistent growth of the relatively new field of art therapy, despite the cutbacks of recent years, is an indirect index of its remarkable power.

Qualitative Evidence

Although quantifiable success in outcome studies would indeed be a strong argument for support, it appears that art therapy is funded as often because of qualitative effects at a more intimate human level. Reading the testimony offered at the Senate Hearings on the Older Americans Act, I suspect it was the eloquent words and stunning pictures of Elizabeth "Grandma" Layton, who described drawing her way out of a lifelong depression at 68, that moved the lawmakers as much as any of the more rational arguments **(Figure 4.5)**. A genuine smile on the face of a previously withdrawn person can often be infinitely more persuasive than any statistics, no matter how stunning. You can see and hear her story on the **DVD (4.5)**.

Perhaps the most convincing evaluation of any therapy is whether or not people feel they were helped. If they do, they are likely to refer others, as well as to come back in the future for further assistance. Most of my own referrals during 25 years of private practice came from what might, for want of a better term, be called satisfied customers.

In November of 1995 *Consumer Reports* published "Does Therapy Help?" It confirmed what clinicians have known for a long time and have been unable to prove, since our assessment of our own effectiveness is naturally seen as biased. But those who come for help, and

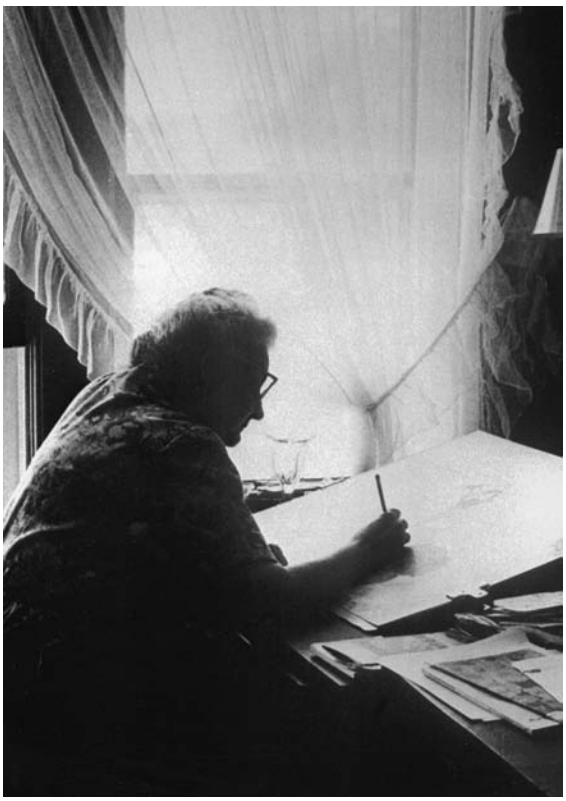

Figure 4.5 A drawing by Elizabeth "Grandma" Layton.

who complain as much as they applaud, told a clear and positive tale: "The results of a candid, in-depth survey of 4,000 subscribers—the largest survey ever to query people on mental health care—provides convincing evidence that therapy can make an important difference." The survey also found that "the longer people stayed in therapy, the more they improved." In a professional periodical, Dr. Martin Seligman, consultant to the *Consumer Reports* study, argued that the findings were comparable to those of conventional outcome research[1] (cf. Hubble et al., 1999; Spiegel, 1999).

Quantitative Evidence

Demonstrating the effectiveness of art therapy through tightly constructed research designs has not been easy to do. This problem has plagued all clinical outcome studies because of the huge number of critical, uncontrollable, and perhaps unquantifiable variables involved in measuring change in human beings. It has been argued that well-designed investigations, which would unequivocally demonstrate art therapy's ability to positively affect its recipients, are desperately needed, in order to get those in power to pay its providers for their services. The few outcome studies available have shown positive results, but most have also had undeniable weaknesses as in an early study I did of the effectiveness of art therapy with some blind children to be described in Chapter 6, "Assessment."

Art Therapy Research

Art therapists interested in research continue to strive to evaluate their work as well as possible in this admittedly complicated area. Most early studies in art therapy were done by people who worked in settings where a lot of research was going on (Kwiatkowska, 1978; Rubin, 2005b; Wadeson, 1980). Some were done by those trained in other disciplines to conduct objective investigations (Betensky, 1995; Rhyne, 1995; Silver, 2005, 2007; Uhlin, 1972). Useful background information is available in *A Guide to Conducting Art Therapy Research* (Wadeson, 1992).

The next generation of art therapy researchers is even more sophisticated in their understanding of research methodology, and is likely to do a better job of assessing the effectiveness of art therapy intervention. Studies so far tend to indicate art therapy's success, but also serve to remind us of the terrific complexity of measuring change. The Research Committee of the American Art Therapy Association (AATA) has provided a resource in a 31-page document, Art Therapy Outcome & Single Subject Studies (rev. 2007).

Art education and therapy researchers have been attracted to models of inquiry from other disciplines as in *Art-Based Research* (McNiff, 1998; cf. also Beittel, 1973). In addition to psychology and psychiatry, art therapists have been drawn to such diverse viewpoints as: philosophy, aesthetics, art history, archeology, linguistics, hermeneutics, anthropology, ethnography, sociology, and ethology. Our British colleagues, equally uncertain about quantifying the creative process, have published three collections of research (Gilroy & Lee, 1995; Payne, 1994), the most recent taking into account the current demand on the part of funders for "evidence-based practice" (Gilroy, 2006).

Research is most effective when it helps us to modify and improve what we do. From studies of neurologically handicapped children, for example, I learned that drawing with white chalk or crayon on black paper helps a child to work at a higher developmental level than drawing the same thing with black on white (Uhlin, 1972). From another set of studies with normal children, a similarly useful finding: when the parts of a human figure are

dictated aloud, a young child's drawing is more integrated than when it is requested in a global fashion—that is, when the child is simply asked to "draw a person" (Golomb, 1974).

The Art Product in Evaluation

There are many ways of assessing the effectiveness of work in art therapy, both directly and indirectly. One that is unique involves the art product—which is available for reflection or measurement, like a taped or transcribed verbal interview. It is possible to evaluate single products, a sequence of work from a session, art done during some period of time, or art produced over the entire course of therapy.

The art can be evaluated by the therapist alone or with the patient. For more objectivity, someone not involved in the process can assess the product(s). The art can be looked at in a global, phenomenological way. It is also possible to assess broadly descriptive areas like subject matter or style, using some sort of rating manual and scale. Finally, the art can be assessed by measuring such quantifiable variables as details, placement, composition, color usage, or specific content items. You will find examples of each of these in Chapter 6, "Assessment."

The Art Process in Evaluation

Unlike verbal psychotherapy, which is often studied through analyses of audiotapes or transcriptions of what is said, art therapy involves not only the product, but also the dynamically significant creative process. This can be studied "live" by having observers behind a one-way mirror or in the art therapy space, as in the pilot study at the School for Blind Children **(Figure 4.6)** described in Chapter 6. It can also be viewed and reviewed through videotaped recordings, which can capture the much greater amount of movement and action involved in art (vs. verbal) therapy.

Like analyses of the art, observational possibilities range from global judgments to the identification of specific behaviors. As with products, investigations that aim at quantification usually involve rating scales of some sort. Whether the researcher is measuring what they say they are (validity), and whether the scale is dependable (reliable), are questions of

Figure 4.6 A blind child in an art assessment.

concern to anyone aiming at objectivity. Many art therapists, stimulated by the demand for accountability, are working creatively at developing reliable and valid modes of assessment, some of which are noted in Chapter 6.

Why Art Therapy?

The chapters that follow this one deal with the many approaches to doing art therapy, the uses of art in assessment, the rationale for and range of possible technique(s,) and an overview of the people we serve and the places where we serve them. Before getting into the what, how, who, and where of art therapy, however, this chapter would be incomplete without a brief look at the why: some of the basic reasons why art therapy works. While other good reasons could be added, I believe that most art therapists would agree with the following rationales.

Knowing the rationale for art therapy can be helpful when explaining or justifying what they are doing or want to do. This is true whether the audience is an administrator, a colleague, or the individual(s) they want to motivate to create. Of course this means putting the arguments in a form that will make sense to the particular audience.

One I have not listed below is the possibility that adding art to verbal therapy may shorten the length of the treatment. This hypothesis has yet to be tested experimentally, and given the many variables involved might never be able to be investigated. It is not difficult to explain to a family, however, that engaging in an art evaluation will help you get to know them more rapidly than talking about the situation alone, especially when young children are involved **(DVD 4.6)**.

Art Involves the Whole Person

Even though other modes of intervention can be very effective, and probably more so for certain problems, there are still many persuasive arguments for the special therapeutic value of art. Some are as old as the Greeks, Plato and Aristotle, and embody the notion that there is a unique way of being that only *Art as Experience* (Dewey, 1934) can provide. In truth, the art process offers one of the few ways we human beings have found to utilize and to synthesize all of ourselves—body, mind, and spirit. In the words of Saint Francis of Assisi: "He who works with his hands is a laborer. He who works with his hands and his head is a craftsman. He who works with his hands and his head and his heart is an artist."

The cognitive aspect of this idea is implicit in some of the recent studies on cerebral hemispheric dominance. They suggest that what Freud called the "primary process" is not inferior to "secondary process" thought, but that they are complementary modes of information processing, each developing throughout our lives. These studies also support the idea that an integration of the two kinds of thinking represents an optimal cognitive state. Perhaps that is what psychiatrist Sylvano Arieti (1976) meant when he proposed that creativity utilizes a unique form of thought, which he called the "tertiary process." At a physiological level, while our understanding of cerebral functioning is still relatively primitive, we do know that both the right and left hemispheres of the brain are involved when people are creating, and that they must interact effectively in order for art-making to occur. Recent advances in clinical neuroscience are further supportive of the relationship between brain physiology and the creation of art (Hass-Cohen & Carr, 2008).

Much of Our Thinking Is Visual

We have abundant evidence—from such normal phenomena as dreams and such abnormal ones as hallucinations—that much of what is encoded in the mind is in the form of images. In

fact, there is no question that a great deal of human thought, at all levels of consciousness, is what psychologist Rudolf Arnheim (1969) called "Visual Thinking." Mardi Horowitz (1983), a psychoanalyst and psychiatrist who did considerable research on imagery, used both art and mental imagery in therapy. He suggested that there are good neurological reasons why people can gain access to material not otherwise available by visual means.

Psychiatrist Louis Tinnin has also proposed several physiological explanations for the effectiveness of art therapy, citing the fundamental biological processes in nonverbal communication, mimicry, and the placebo effect. With art therapist Linda Gantt, he has developed a powerfully effective methodology for helping individuals who have been traumatized, based on theories related to brain functioning (Tinnin & Gantt, 2000).

Memories May Be Preverbal or Forbidden

A variety of conditions can be the outcome of a childhood environment full of painful experiences. Because their origins are so early, they are often more easily accessible through a nonverbal therapy. This is especially true for eating disorders, addictions, and severe narcissistic disturbances—in fact, most of what are commonly called borderline conditions, as well as many other personality disorders. Since their development has been distorted and fixated at preverbal levels, such individuals respond well to art therapy, which often becomes the treatment of choice, since it can help them to express, to see, and to accept their tumultuous internal states.

Whether because we are dealing with memories from a period before the patient had words, or because there is an injunction that a traumatic memory must not be told, much of the anguish behind the dissociative disorders is most accessible through images. It is no surprise that, as inhibitions about reporting have been overcome, more art therapists are working with people who have suffered abuse, who may be unable to speak about their experiences, but who can use art as a way of "telling without talking" (Cohen & Cox, 1995).

In *Bridging the Silence*, dance therapist Susan Simonds (1994) argued for the use of "nonverbal modalities in the treatment of adult survivors of childhood sexual abuse." Simonds proposed that a combination of movement and art therapy was optimal, due to the inevitable body image distortions that are the residue of such painful assaults.

Posttraumatic stress disorder (PTSD) seems to be increasing, probably because it is more often recognized by clinicians and also because of the increasing number of cataclysmic events, such as what happened on 9/11, which create stress in observers as well as participants. Since such traumatic experiences tend to render those involved speechless in relation to them, art therapy is often the treatment of choice where PTSD is common, as in veterans' hospitals (American Art Therapy Association [AATA], 2006). Art therapy with those who have suffered abuse is being described with increasing frequency (Brooke, 1997, 2007; Cohen & Cox, 1995; Gil, 1991; 2006a, 2006b; Hagood, 2000; Murphy, 2001; Spencer, 1997; Spring, 1993, 2001).

Negative Ideas and Feelings Are More Easily Expressed in Art

In addition to the fact that the images at the root of a disorder may be inaccessible in other ways, there is another advantage of art therapy. Because art is symbolic and essentially value free, it is an easier modality than words through which people can begin to express their dark side. These disowned aspects of the self are called the shadow by Jungian therapists. It is always hard to represent what has been rejected, either consciously because of shame or unconsciously due to anxiety. But if the unacceptable thoughts, feelings, and impulses can be seen and accepted, the individual is then free to use otherwise-destructive energy for more constructive aims.

Art Helps to Face What's Inside: LAURIE (38)

Laurie, a woman in her late thirties, had seen four therapists prior to giving treatment one more chance. She announced from the beginning that if it didn't work, this was her last such effort; she would just have to accept the feared "fact" that she was incurable. Her therapy, which began as twice weekly and became a four-times-per-week analysis, turned out to produce more inner change than she had first imagined possible. Art, however, was a loaded issue from the first. Laurie was openly resistant, saying that she feared making a fool of herself, a common concern among adolescents and adults. Over time, we wondered if her negativism was a disguised form of oppositionalism—that is, "You can't make me!"

In addition, we began to think that perhaps it was not so much that Laurie feared exposing her lack of skill, but rather that she feared what she would "see" inside of herself. Her many anxieties—about things like public speaking, doctor visits, and examinations—especially those that penetrate beneath the surface, like x-rays or mammograms—all seemed related to a fear of what was inside being made visible, of being "exposed."

This particular anxiety was clearly at work when she produced her first doodled drawing during the second year of treatment. She had recently confessed that she liked to doodle, a creative way of "binding" or containing her pervasive anxiety. But Laurie was so self-conscious about being watched that I offered to leave the room, and did so briefly. After she had finished and showed the drawing to me, I was impressed by the skillful linear design she said was typical.

When she looked at it, however, and was asked if it reminded her of anything, she replied with shock that it looked like a "witch," and an evil one at that **(A)**. She then confessed that she was sure that she was really bad at the core, and that this frightening image, which she titled "It's My Fault," reflected an ugly truth. As time went on, Laurie disclosed her secret conviction that she had "powers," giving her a feeling of control in relationships. When we discovered that this was a grandiose fantasy—born of her helplessness in the face of two parents traumatized by the Holocaust—she understood it in a new way. Sadly she complained that she was "losing" her "powers," and at first felt even more vulnerable.

Although there were few drawings during the rest of our work, there were many references to the witch inside. Her appearance had been vivid and memorable to both of us, and helped Laurie to see how her fantasized "powers" had made her feel so dangerous—"It's all my fault." As she slowly accepted and understood the rage of the frightened child inside her, Laurie found the loss of her "powers" to be a source of relief.

Over time she was able to be more understanding about her terrorized parents' inability to calm her, and to accept her own rage as reasonable for a little girl. It had been magnified by her imagined "powers," which she was able to give up as the witch inside was gradually replaced by a more balanced sense of herself as both good and bad.

Although overtly pessimistic about therapy and herself, Laurie harbored magical fantasies, which emerged during the final phase of our work. One, for example, was that if I would only metaphorically "bop her over the head," that would cure her. Just as she had gradually accepted her own and others' limitations, so she came to terms with the limits of psychotherapy and the "powers" of the therapist. Laurie had a wonderful sense of humor, which helped her to bear her disillusionment, and she eventually felt considerably better.

Art Offers Unique Possibilities for Expression

By creating art people can say things that are impossible in words, such as representing different times and places in the same pictorial space. These can be simultaneous, as in what

I have called a Life Space picture, representing what is most important in a person's life at that time symbolically on a large sheet of paper (18 x 12 or 18 x 24) (**B**). They can also be sequential, as in a Life Line where people are invited to represent the ups and downs in their lives using a line that can be varied in size and shape as well as images symbolizing major events (Rubin, 2005b). On the **DVD** you can observe a man spontaneously representing his life in an abstract line **(C)**.

In a similar fashion, a single work of art can express and synthesize apparently incompatible affective states, such as love and hate. This is one reason why art is especially useful in the task of internal psychological integration, a major goal of most psychotherapy and self-development regardless of the clinician's orientation **(D)**. People want to feel more "together," and being able to put things together in a picture is one way to begin the process of feeling more together internally.

Art therapy is also especially valuable for any group in turmoil, whether living in a home (a family), an institution, or a community. Although people cannot talk simultaneously and still hear each other, different individuals can work on their art at the same time **(E)**. Similarly, people cannot communicate with words unless they can take turns, whereas creating jointly in art can occur in a wide variety of ways **(F)**.

The Art Product Is a Helpful Presence

The presence of the art makes for a clinical situation that is very different from verbal psychotherapy. Even in individual art therapy, there is always a "third party" in the room. The art acts as a bridge between patient and therapist, and as a transitional or transactional object between the two **(Figure 4.7)**. Paradoxically, the art serves both to reduce self-consciousness and to enhance self-reflection, just because of its otherness (cf. Schaverien, 1992; Schaverien & Case, 2007). On the **DVD (G)**; you can see Mala Betensky inviting an adolescent who is cognitively challenged to look at and reflect on what he has drawn with the simple question "What do you see?" (Betensky, 1995).

Figure 4.7 Patient and therapist looking at a painting.

Figure 4.8 Art is portable and can happen anywhere.

In group or family therapy, the presence of the art is also helpful. Whether responding to each other's creations, or working together and reflecting on the process, a jointly made product, or both—looking at self, other, or the group is greatly facilitated by being able to see these in the art rather than in the person(s). On the **DVD** you can observe members of a family exploring their reactions to one another's artwork in a family art evaluation **(H)**.

Art Is Flexible and Versatile

Another of art therapy's greatest assets is its remarkable versatility. Art can be used with people of any age, and can be adapted to almost any disability or setting. Art is also portable, so it can be offered to people who need to be seen at home, who are immobilized in hospital beds **(I)**, or who are stuck in shelters **(Figure 4.8)**. Art is especially useful as therapy in crisis situations and settings, since many media permit rapid, easy expression, which is vital when trauma leaves someone speechless **(J)**. Art is versatile in yet another fashion: it can be used in as many ways as there are theories of rehabilitation, treatment, education, and growth.

Art Normalizes Psychotherapy

Another significant asset of art therapy is that because art activities naturally occur in normal settings like schools, churches, and community centers, art therapy tends to be much less threatening to many people than verbal psychotherapy.

In the 1970s, a psychologist and I were able to offer training in what we called "Art-Awareness" to people like youth group leaders and others working with teenagers (Rubin, 2005a) **(K)**. These trainees then worked under our supervision with adolescents in the community. We also held classes for art teachers in schools, colleges, and community centers, in order to sensitize them to do their job more therapeutically.

So even when art as psychotherapy isn't indicated, the services of an art therapist as consultant, trainer, or supervisor of other caregivers can extend the therapeutic benefits of art to more individuals **(Figure 4.9)**.

Figure 4.9 Art therapy workshop for teachers—Judy Rubin.

The Creative Process Is a Learning Experience

Many have pointed out parallels between psychotherapy and the creative process, another likely reason for the effectiveness of art therapy. Both involve the breaking down of old structures in order to give birth to new ones, as well as the confrontation of confusion and chaos within a containing framework. The creative process also offers an opportunity to experiment with new ways of seeing or being. As Edith Kramer (1958) eloquently said:

> Art is a method of widening the range of human experiences by creating equivalents for such experiences. It is an area where experiences can be chosen, varied, and repeated at will.

Art Is a Natural "High" That Also Heals

We have barely scratched the surface of what is possible through art for our spiritual health, especially since society is going through an extremely painful period, hopefully one of transition. In a world where happiness is often sought through mind-altering drugs and where pent-up rage erupts in senseless violence, making art is a means of safely sublimating

otherwise destructive urges and experiencing a safe altered sense of reality, of aliveness. On the **DVD** an adolescent puts this quite eloquently **(L)**.

As Elinor Ulman said years ago, being deeply involved in a creative process is "a momentary sample of living at its best." The sensory and spiritual pleasures of art-making are profound, enriching lives already full, and brightening those that are far too dim. Most art therapists see art not only as a form of "symbolic speech" that augments verbal ways of knowing, but as a deeply healing activity.

Ulman thought that one reason for its power to help was that "art is the meeting ground of the inner and outer world" (1971). Ten years earlier (Ulman, 1961, in Ulman & Dachinger, 1975), she had also written about art:

> Its motive power comes from within the personality: it is a way of bringing order out of chaos—chaotic feelings and impulses within, the bewildering mass of impressions from without. It is a means to discover both the self and the world, and to establish a relation between the two. In the complete creative process, inner and outer realities are fused into a new entity.

In addition, because art-making involves the whole body and is both sensory and kinesthetic, the very act of touching, shaping, and manipulating materials can be a source of deep pleasure. And, when the process has come to an end, viewing and showing the finished product(s) can be a wonderful source of pride and enhanced self-esteem **(Figure 4.10)**.

Creating something unique with materials facilitates much more, however, than a sense of accomplishment. Having an effect on even a small piece of material reality is a powerful antidote for feelings of shame and helplessness. Without a sense of efficacy of agency, it is very hard—if not impossible—to feel hopeful about life. For those who are isolated or gravely impaired, making art can truly enhance the quality of life **(Figure 4.11)**.

Figure 4.10 Pride in one's product is highly therapeutic.

Figure 4.11 A nursing home patient engaged in creating.

Why Art?

When we ask, "Why art therapy?" it implies another question: "Why art?" It has been said that "Art is a way of making ordinary experience extraordinary," or as Dissanayake (1995) wrote, of "making special." This idea returns us to the roots of art therapy, which are deep and ancient, and to its branches, which are able to flower in so many different ways.

I think the titles of two books by a poetic art therapist say it well: that *Art Is a Way of Knowing* (Allen, 1995) and *Art Is a Spiritual Path* (Allen, 2005). I also believe that artists and clinicians alike make use of *Art as Medicine* (McNiff, 1994). If therapy means to heal, and hopefully to cure, then art may really be the ideal medicine for the human soul, the best way for the Spirit to know and to actualize the Self.

There are many ways to think about why art is therapeutic. One was beautifully articulated by a psychologist named Ley (1979): "One cannot use a left hemispheric key to open a right hemispheric lock." Another was written by a psychiatrist named Jakab: "The nonverbal aspect of art psychotherapy holds an important and unique position in the realm of mental health work, for it gives the clients an opportunity to listen with their eyes."

Another eloquent statement of why and how art is therapeutic was written by art therapist Edith Kramer (2000): "Since human society has existed the arts have helped man to reconcile the eternal conflict between the individual's instinctual urges and the demands of society. Thus, all art is therapeutic in the broadest sense of the word" **(Figure 4.12)**.

Perhaps my favorite, however, was said by a patient in a mental hospital to E. M. Lyddiatt (1971), a British art therapist: "In the Art Therapy room my sick self found my whole self and the therapist, by total, unquestioning acceptance of me and the things that I painted, encouraged me to believe in myself as a valid person."

Back to Basics

The most recent trend in the field of art therapy in the United States has been a return to the art studio (C. H. Moon, 2002). The concept of the open studio articulated by Pat Allen in Chicago and offered to homeless individuals by Janis Timm-Bottos in New Mexico has

Figure 4.12 A person can create only when safely "held."

become hugely popular among art therapists. AATA now has an Art Committee, originally ad hoc but now standing, which sees to it that art is central to the annual conference, which always has an open studio space where attendees can go to create throughout the meeting. Each day's presentations begin with a slide show of art submitted by AATA members.

A similar kind of development, beginning in 1999, was what is known as QuickDraw, during which well-known art therapists create in a specified space and time where they can be observed by conference participants. Not only do they often answer questions informally during the process of creating, they also respond to queries using a microphone in a discussion that is uniformly stimulating and enlightening. On the **DVD** you can see and hear Shaun McNiff first drawing and then reflecting on the experience **(DVD 4.7)**.

As artists become involved in using the arts in healing, most evident in arts medicine, this trend is likely to continue within the world of art therapy as well. There has always been a tension between artist and therapist-self for many individual art therapists, some of whom have continued parallel careers as active, exhibiting artists (Kramer, 2000; Lachman-Chapin, 1994).

Having needed to prove our credentials as therapists in the early days of the field of art therapy, we also ran the risk of clinification and of forgetting our roots in art. The back to basics movement reaffirms that which is unique to art therapy: Art. The challenge for the 21st century is to demonstrate that art therapy can provide for human beings what is missing in the technology and accelerated pace that now dominate our way of life, to satisfy what many believe to be a basic need to create—in order to feel and to be fully alive.

Endnote

1. From "The Effectiveness of Psychotherapy: The *Consumer Reports* Study, by M. P. Seligman, M. P., 1995, *American Psychologist, 12(5)*, 965–974.

CHAPTER 5
Approaches

As a psychotherapist I found it particularly heartening that the use of art in therapy seems to have the eἀect of reducing the diἀerences between Freudians, Jungians, Kleinians, and adherents of other schools … Art not only bridges the gap between the inner and outer worlds but also seems to span the gulf between diἀerent theoretical positions.

Anthony Storr

Multiple Paths: Multiple Perspectives

The reader will recall that there were a number of individuals from different fields who, in one way or another, pioneered the use of art in therapy. Each of them had a primary identity in another discipline, whether it was art, education, or mental health. It was natural, therefore, that their ways of understanding art therapy were disparate, influenced as they were by their personal histories.

Founding editor Ernest Harms (1973) expressed his concern about this variety in the second issue of *Art Psychotherapy*: "What we find designated today as art therapy or art psychotherapy presents a conglomerate of undertakings with little coherence."[1] Indeed, it would probably be accurate to say that if truth be told, there have always been as many different approaches as there are art therapists.

Nevertheless, it would be inaccurate to suggest that each one is completely idiosyncratic, having nothing in common but a shared basis in art and therapy. While every art therapist's way of working is stylistically unique, it is still possible to talk about different perspectives. Just like practitioners of verbal therapy, art therapists have grounded their work in a variety of theoretical frameworks that have expanded as the profession has developed.

In 1983, I invited some individuals who practiced art therapy from different points of view to write chapters on how they had translated a particular theory into technique. The book that resulted, *Approaches to Art Therapy* (Rubin, 1987/2001), contained descriptions of a number of orientations; and because new approaches have since evolved, there is a second edition with six new chapters on even more particular ways of thinking and working.

To grasp any one of them requires extensive study and close supervision by an experienced clinician. This chapter offers a broad overview of different ways to view, to understand,

and to do art therapy. These multiple perspectives define the discipline as much as do its common underpinnings.

Psychodynamic Approaches to Art Therapy

Historically, art therapy's roots were in the then-dominant mode of understanding, psychoanalytic theory. Psychoanalysis is only one of many ways of trying to understand how and why people function as they do. But it is the oldest and most elaborate among modern therapeutic approaches, and has influenced all of the others, which are either modifications of or reactions to it. Both *Freudian Psychoanalysis* and *Jungian Analytical Psychology* are based on an understanding of the dynamics of the patient's internal world. They are called *psychodynamic* because they assume that unresolved issues cause unconscious conflict, exerting tremendous power and resulting in painful symptoms. Because they have been repressed as too distressing, they are often unconscious and need to be discovered through bypassing defenses, as in art.

There are a variety of approaches within both analysis and analytic psychotherapy. Many emphasize developmental as well as interpersonal phenomena, exemplified by the studies of "attachment" (Wallin, 2007) as well as "relational" approaches (Mitchell & Aron, 1999). Contrary to popular misconceptions, psychoanalytic therapy deals with the present as well as the past, has educational as well as cognitive components, relies heavily on empathy, and builds on strengths.

Despite rumors of its demise, contemporary psychoanalysis is alive and well. In fact, it is extremely fertile, teeming with new ideas about both theory and technique, many of them relevant to art therapy. In the second edition of *Approaches*, I invited individuals to comment on the group of chapters in each section. Joy Schaverien, an art therapist from Great Britain—where analytic modes of thinking and working are still dominant—wrote a thoughtful commentary.

Freudian Psychoanalysis

The two main pioneer art therapists each based their approach on the theory developed and modified by Sigmund Freud. Naumburg emphasized *insight,* uncovering unconscious forces through images and associations to them. Kramer focused on *sublimation* through the creative process, a form of ego mastery. Many art therapists have followed in their footsteps, like myself (Rubin, 2001) in the Naumburg tradition or Lani Gerity (1999) in the Kramer tradition.

Most art therapists who think analytically have emphasized one or another component of Freudian theory. Some examples are: Margaret Naumburg's (1966) stress on the *dynamic unconscious,* Edith Kramer's (2000) on *sublimation*, Laurie Wilson's (Rubin, 2001) on *symbolism,* Arthur Robbins's (1997; Rubin, 2001) on *object relations*, Mildred Lachman Chapin's (Rubin, 2001) on *self-psychology*, and Myra Levick's (1983) on *defense mechanisms*. All analytically based approaches value and foster free expression of the person's own imagery. Some emphasize spontaneity, while others stress the achievement of formed expression.

Psychoanalysts—both medical, like D. W. Winnicott (1971b) and Nolan D. C. Lewis, and nonmedical, like Madeleine Rambert (1949) and Marion Milner (1969)—were among the first to use drawing and painting, especially with regressed or resistant patients. On the **DVD (5.1)** you can hear Marion Milner talking about a patient whose treatment she described in *Hands of the Living God* (1969) **(A)**. Many other clinicians were influenced by analytic thinking about the role of the unconscious in mental distress and its tendency

to speak in images. Several pioneered in doing such work, like Ainslie Meares **(B)** (1957, 1958, 1960) in Australia, Ralph W. Pickford (1967) in Scotland, Irene Jakab (1956/1998) in Hungary, and Mardi Horowitz (1983) in America.

Melanie Klein (1932), who used drawing as one of many modalities in child analysis, was a disciple of Freud who developed her own unique ideas. Her theories have been applied to art therapy by Weir, (Dalley et al., 1987). Indeed, the dominance of analytic thought among British art therapists is in striking contrast to recent developments in the United States, where it was originally most the most common orientation.

Margaret Naumburg called her approach "dynamically oriented art therapy," relying on patient associations to images illustrated by Judy Rubin on the **DVD (C).** Edith Kramer called hers "art as therapy" **(D)**, relying on the ego-building potential of sublimation, a psychoanalytic defense mechanism. Laurie Wilson stressed the value of art in promoting symbolization **(E)**. Arthur Robbins focused on the importance of internalized images in the psyche, what Freud called "object relations" **(F)**. Mildred Lachman Chapin highlighted the value of Self Psychology, an analytic orientation developed by Heinz Kohut, and developed a technique of mirroring what the patient was concerned with by drawing with him **(G)**.

In addition to the approaches outlined in this chapter, some art therapists—like Shirley Riley—have been very enthusiastic about other ways of conceptualizing the treatment relationship, such as narrative therapy, postmodernism, and social constructionism (Riley, 1999, 2001). My own sense is that these terms have to do with working in a more egalitarian way, which is not so different from what is currently known as "relational psychoanalysis" (Mitchell & Aron, 1999).

Analytic therapy, whether through art or words, relies on the method of *free association,* which is illustrated in the following vignette.

Free Association in Art Imagery: LINDA (8)

Linda was a sad, inhibited eight-year-old who had come for several assessment sessions before she and her parents agreed to child analysis (four sessions per week). In her first analytic hour, she worked with soft-colored wax, creating in rapid succession a series of three-dimensional images, which were later made into candles by the insertion of wicks.

Although Linda thought of making a turkey for the first, she decided on an "Orange … because a turkey is too hard." She bragged that she would make "a whole bunch." She then pressed the round piece of wax on the table saying she had to make it "square," and talked about her older sister coming home from college for Thanksgiving "tonight or tomorrow." She added dots to the square, and called it a "Dice." She then reiterated the concern she had voiced in the beginning of the hour: "I'm wondering if—if—who's your favorite person that goes with you?"

Linda's second product was a roundish piece of yellow clay on which she put "gold dust," calling it "A Gold Lump." Her third was a red "Apple," copied from a picture on a box. She complained about how hard it was to shape the wax, saying, "I'm gettin' tired of it. I thought it was pretty at first sight, but I didn't know it was so much trouble!" She made a leaf for her apple, and told me that she was missing a party but didn't mind. She then joked about her friend's mother being "a wicked witch."

Her next effort was called "An Eiffel Tower"… "very tall, one of the tallest!" Linda told a story about "a giant magnet and it was sucking everything up and it sucked the Eiffel Tower." She told me I was "a funny person." She then decided she would give away all her candles ("They're just candles") as gifts, saying , "I love giving things. I really want the Eiffel Tower because it isn't so pretty … I think I'll keep that." In response to my questions about

Figure 5.1 Linda welcoming the next patient.

what she had created, Linda imagined that the dice belonged to "a famous game-player" and that the apple was owned by "the best person in the world—the King!"

What is striking is how very much Linda was able to tell about herself through free association with art media in this relatively brief segment from her first analytic hour—about her hunger for attention (supplies), her jealousy of siblings (my other patients), her difficulty with anger toward her mother (her friend's mother is a "wicked witch"), and her defense of reaction-formation … whereby this hungry, needy child who wants to suck up everything like a giant magnet, ends up deciding to give all of her creations to others as gifts. In a later version of this defense, Linda would welcome the next child analytic patient, of whom she was really quite jealous, by writing cheerful greetings **(Figure 5.1)** on the floor **(H)**.

Jungian Analytic Therapy

Margaret Naumburg was analyzed not only by a Freudian, A. A. Brill, but also by a Jungian, Beatrice Hinkley—who analyzed her sister Florence Cane as well. Some of Jung's ideas about symbolism and imagery were incorporated into her formulation of what she called "Dynamically-Oriented Art Therapy" (Naumburg, 1966). Jung's thinking has gradually become popular among American art therapists, and has remained appealing in Great Britain, where one of the first books on art therapy was by a Jungian (Lyddiatt, 1971).

Jung believed that all human beings were born with a *collective unconscious,* and that there were universal *archetypes* common to all cultures. The similarity of visual symbolism in widely separated artistic traditions was part of the evidence for this hypothesis. Jung's notions about *symbolization* were quite different from Freud's. Jung emphasized the capacity of symbols to *reveal* hidden ideas, while Freud stressed their ability to *conceal* unconscious feelings and fantasies. Jung himself had found that building with natural materials and painting mandalas were helpful in his own self-analysis.

Because he felt that there were messages to be "heard" in visual symbols, Jung's approach to mental and artistic imagery was respectful and intuitive—much less analytical and deductive than Freud's. He advocated the use of movement, drama, and visual imagery in the technique he called "active imagination," which was a creative way of amplifying ideas and feelings in

Figure 5.2 Edith Wallace, Jungian analytical art therapy.

therapy (Chodorow, 1997; Fay, 1994). He wrote: "An emotional disturbance can also be dealt with in another way, not by clarifying it intellectually, but by giving it visible shape" (Jung, 1916/1952). Some art therapists, while they are not Jungian analysts, have been attracted to the notion that images "speak" to the artist and have developed methods that enhance the likelihood of learning from such messages (Allen, 1995, 2005; Kapitan, 2003; McNiff, 1995).

Jungians are more likely than Freudians to promote art activity as part of analytic therapy, making Jungian analysis attractive to artists like Jackson Pollack (Wysuph, 1970) and Peter Birkhauser (1991). Several analytical psychologists have published book-length case studies (Baynes, 1961; Harding, 1965; Wallace, 1990; Weaver 1973). Jungian analyst Edith Wallace **(Figure 5.2)**, a psychiatrist and psychologist, also contributed a chapter to *Approaches* (Rubin, 2001).

The arts played a central role at Withymead Centre, a unique therapeutic community run by a British Jungian analyst named H. Irene Champernowne (Stevens, 1986). Michael Edwards, one of the art therapists who worked there, later pursued Jungian training and contributed another Jungian chapter to *Approaches* (Rubin, 2001). In 1992, Joy Schaverien published *Analytical Art Psychotherapy in Theory & Practice* (1995) and later extended her theoretical framework to include ideas from other psychoanalysts like Bion (1991), Winnicott (1971a, 1971b), and Lacan (2007). A recent book from Great Britain includes chapters by Schaverien and other art and drama therapists with an analytical psychotherapy orientation (Searle & Streng, 2001).

As a group, analytical psychologists are less likely to work with children, perhaps because Jung never articulated a fully developed theory of human development. A few, however, used art extensively (Allan, 1988; Fordham, 1944; Jeffrey, 1995). Furth, like his mentor Bach (1990), helped sick children through art. Dora Kalff (1980) was inspired by Margaret Lowenfeld's "World Technique" (Lowenfeld, M., 1971, 1979) to invent what she called "sandplay," a technique used with patients of all ages (Bradway & McCoard, 1997; Carey, 1999; Homeyer & Sweeney, 1998; Labovitz Boik & Goodwin, 2000; McNally, 2001).

Although her early training was in *Freudian object relations theory*, movement therapist Penny Lewis's *Creative Transformation* (1993) reflected her *Jungian* studies as well. Jungian

psychiatrist David Rosen, like Lewis, embraced a multimodality method in his treatment of depression. It is no accident that the word *transformation* is in the titles of both of their books (Rosen, 2002). Jungian approaches often include a strong mystical and spiritual component.

Several art therapists have used Jung's thinking as one component of their conceptual foundation. When Keyes's 1974 book was reprinted (1992), a supplement entitled "On Active Imagination" was added. Indeed, the best collection of Jung's own writing on that topic was compiled by a dance therapist (Chodorow, 1977), and the explanation by movement therapist Carolyn Grant Fay (1994) is also excellent **(I)**.

As for art therapists, Lusebrink (1990) incorporated the idea of *archetypes* and the method of *active imagination* into her work. Kellogg (1980, 2002) spent many years exploring the use of the *mandala* for both diagnosis and therapy, a technique also embraced by others (Fincher, 1991). And Corbit and Fryrear's 1992 book on *Photo-Art Therapy* was subtitled *A Jungian Perspective*. And, as Jung's ideas have been "re-visioned" by contemporary analytical psychologist James Hillman (1977), they have become even more attractive to art therapists.

Humanistic Approaches to Art Therapy

Another major group of therapies developed in reaction to the psychoanalytic focus on the past, on the unconscious, and on conflict. These are the humanistic approaches, which emphasize the acceptance and development of individuals in the present **(DVD 5.2)**. Such approaches were very popular in the 1960s during the flowering of the *human potential movement*. Humanistic psychology offered a *wellness* model of change, as opposed to a medical model of *illness*. Josef Garai, who wrote that chapter in *Approaches* (Rubin, 2001), also included "Holistic" in the title **(A)**.

Holistic ideas about healing are an outgrowth of humanistic ones, as are those in what is known as *transpersonal* psychology and psychotherapy. Abraham Maslow,[2] an early humanistic psychologist, emphasized "self actualization," or the fulfillment of the individual's innate potential for growth. He also described "peak experiences," similar to Ulman's characterization of art-making as "a momentary sample of living at its best" (Ulman & Dachinger, 1975).

Person-Centered Approach

This approach, developed by Carl Rogers**,** was originally called the *client-centered* approach. It is based on the therapist's *unconditional positive regard* for the patient, and the powerful effect of *empathy* (feeling with) as a way of fully responding to the person in pain. His daughter, Natalie (Rogers, 1993) was taught by Maslow. Initially trained as a play therapist and a dancer, she used art along with movement, music, and drama in what she called "Person-Centered Expressive Therapy" **(B)**. A recent methodological contribution to this orientation is Laury Rappaport's adaptation of the work of Carl Rogers's colleague Eugene Gendlin in *Focusing-Oriented Art Therapy* **(C)** (Rappaport, 2009).

In Great Britain, Silverstone (1997) developed a training course called *Art Therapy: The Person-Centred Way*. A recent publication from the United Kingdom contains papers on the arts therapies in "person-centered dementia care" (Innes & Hatfield, 2001).

Adlerian

Alfred Adler, a former colleague of Freud's who created *Individual Psychology,* inspired several American art therapists. One was Rose Garlock, who led groups at an Adlerian social club in New York for many years and contributed a chapter to the first edition of *Approaches*

to Art Therapy (Rubin, 2001). Another was Sadie Dreikurs (1986), wife of Adler's best-known American disciple, Rudolf Dreikurs. She began her work in a Chicago hospital in 1962, and taught her approach in Adlerian institutes. Although Adlerian approaches to therapy are much less common than they were 20 years ago, there is an art therapy training program at the Adler School of Professional Psychology founded by Judy Sutherland (Cf. Kerr et al., 2007).

Gestalt

Like many other humanistic approaches, *Gestalt therapy* also involved modifications of psychoanalytic theory and technique. Like Rogerian therapy, it emphasized the here-and-now. Unlike that approach, it required a more active role by the therapist. Gestalt therapy was the creation of an analytically trained psychiatrist, Fritz Perls, who integrated his dynamic understandings with the findings of Gestalt psychology. The latter was an experimental approach that focused on sensation and perception. A major area of interest was *visual* perception, as in the work of Rudolf Arnheim (1954, 1967, 1969), who influenced many art therapists, including his student, Shaun McNiff (1988).

Joseph Zinker (1977), a Gestalt therapist and sculptor, wrote about his multimodal use of expression. Violet Oaklander, (1988) another Gestalt therapist, described her use of art and other expressive modalities in therapy with children, adolescents, and families. On the **DVD (D)**, you can see her working with an angry boy (www.violetoaklander.org).

One art therapy pioneer trained by Perls also participated with him in the human potential movement. Janie Rhyne **(Figure 5.3)** called her 1973 book *The Gestalt Art Experience*, and led workshops in that approach **(E)**. Later in her career, Janie Rhyne became interested in George Kelly's *Personal Construct* theory of personality. She explored what she called "mind-state drawings" for her doctoral research. Rhyne described her findings and their application in her clinical work, elaborating these ideas in her chapter for *Approaches* (Rubin, 2001). Her later thinking is in the Foreword and Afterword to the 1995 revision of her book, whose new subtitle—*Patterns That*

Figure 5.3 Janie Rhyne, Gestalt art therapy.

Connect—reflects her growing interest in both personal constructs and *cybernetics* (the study of feedback systems).

Ericksonian

Milton Erickson was a psychiatrist who created his own personal synthesis of various philosophies and techniques into a highly inventive approach. Like other humanistic therapists, he emphasized human potential, and advocated a collaborative versus an authoritarian model of psychotherapy. He pioneered in many techniques, such as the clinical use of hypnosis and what he called "creative reframing."

In a 1940 case study with analyst Lawrence Kubie (1958), Erickson described using "Automatic Drawing" to treat a case of "Acute Obsessional Depression"—an early instance of art therapy. Although art therapists have not been notably involved in Ericksonian therapy, both rely heavily on *metaphor,* as in the use of art by Mills and Crowley (1989).

Phenomenological

A strong current, with its roots in 19th-century philosophy, also had a profound impact on 20th-century psychology. Known as *phenomenology,* the essence of the theory is the uniqueness of each individual's experience of reality at each moment in time. In psychotherapy, the clinician concentrates on helping the patient to focus keenly and intensely on each moment, to fully know the phenomenon of *being-in-the-world* (existing). Art therapy pioneer Mala Betensky **(Figure 5.4)** developed an approach based mainly on phenomenology, into which she integrated elements of Gestalt psychology as well. She wrote two books describing her work (Betensky, 1973, 1995) and contributed a chapter to *Approache*s (Rubin, 2001). On the **DVD** you can see her working with an adolescent girl whose art she discussed in her second book **(F)**.

Existential

Existentialism also began in philosophy and was then embraced by a number of psychologists and psychiatrists. A strong element was the centrality of *meaning*, a key factor in art therapist Bruce Moon's work with adults, described in his book *Existential Art Therapy* (1995). Moon has continued to write about his practice which is, like most humanistic

Figure 5.4 Mala Betensky, phenomenological art therapy.

Figure 5.5 Pat Allen, the open studio approach.

approaches, profoundly client centered (Moon, 1992, 1994, 1996, 1998, 2007). Moon contributed a *Commentary* to the section on humanistic approaches in the second edition of *Approaches* (Rubin, 2001). On the **DVD** he can be seen working alongside a supervisee **(G)**.

Although both were psychologists and not art therapists, Clark Moustakas (1953, 1959), who worked with children in play therapy, and Rollo May (1975), who saw adults, described *existential therapy* in which *creativity* was synonymous with *mental health.* All humanistic approaches emphasize man's capacity to take charge of his life, to use *free will* and to exercise *intentionality.* In contrast, psychoanalytic approaches stress unconscious dynamics and the power of the *repetition compulsion* to affect even presumably "free" choices (Freud, 1900, 1916–1917, 1923).

"Intentionality" is highlighted in Pat Allen's **(Figure 5.5)** chapter in the second edition of *Approaches* (Rubin, 2001), in which she described its function in the *open studio*—an idea that is further defined and delineated in her books (Allen, 1995, 2005). On the **DVD** you can see a young person following her creative experience in an open studio with *witness writing* in response to the image **(DVD 7.2B)**.

Psycho-Educational Approaches to Art Therapy (DVD 5.3)

Behavioral

Experimental psychologists focus on what can be measured; that is, overt behavior. They have greatly enhanced our comprehension of how learning takes place. We know, for

Figure 5.6 Ellen Roth, behavioral art therapy.

example, that if a behavior is reinforced or rewarded in some way, it will tend to be repeated. We also know that if a behavior is ignored or punished, it is less likely to recur, and that it will eventually "extinguish," or disappear.

This understanding is the basis for techniques that have gained in popularity among clinicians during recent years. *Behavior Therapy* and *Behavior Modification* are approaches in which a systematic description of appropriate and inappropriate behaviors provides the basis for therapeutic intervention. All therapies provide reinforcement for some behaviors and not for others, but except for behavioral and cognitive-behavioral approaches, it is rarely the primary instrument of change.

These approaches have not been especially popular among art therapists, since at first glance they appear antithetical to a genuine creative process. They are not really incompatible, but require—as do all theories—a deep understanding in order to be able to be meaningfully integrated with art therapy.

Behavioral approaches have been used most often with children with disabilities, as in Ellen Roth's **(Figure 5.6)** use of *reality shaping* with emotionally disturbed children who were also cognitively challenged. Her chapter in *Approaches* (Rubin, 2001) outlines a history of behavior therapy, as well as Roth's rationale for her adaptation of its principles to art therapy with these youngsters. The combination of behavioral and cognitive approaches has been used by some art therapists, including Marcia Rosal, who contributed a chapter on its application to her work with a disturbed adult to the second edition of *Approaches* (Rubin, 2001).

Cognitive

Cognitive therapies focus on habitual distorted thought processes, which are thought to underlie maladaptive feelings and behaviors. The therapeutic approach is largely an *educational* one, in which the task is first to identify the patterns of misperception or thought

Figure 5.7 Rawley Silver, cognitive art therapy.

causing the persistence of symptoms. Patients are then taught new and more adaptive ways to think and to behave, using cognitive strategies. While there is an educational element in all therapies, it is not usually the primary mode of treatment.

One of the first to espouse a cognitive approach to therapy was psychologist Albert Ellis, who developed what he called *rational-emotive therapy* (RET) in the 1960s. At the 1982 American Art Therapy Association (AATA) conference, art therapist Sondra Geller and a colleague described how they could "unblock the creative process" for students unable to complete theses who were seen in the George Washington University Counseling Center. They felt that the effectiveness of art therapy was enhanced when combined with the cognitive-behavioral strategies of RET (AATA, 1982 *Proceedings*).

Many art therapists of varied theoretical persuasion have considered the cognitive aspects of art activity to be *central* to its therapeutic power, including people as different in orientation as Edith Kramer (2000) and Janie Rhyne (1995). Shaun McNiff (1986, 1988) developed his ideas about the therapeutic action of art, paying tribute to his mentor, Rudolf Arnheim—the author of *Visual Thinking* (1969). Other cognitive psychologists, like Howard Gardner (1980, 1982) and the Kreitlers (1972), have also been appealing to art therapists because they clarify and value the cognitive operations involved in making art.

Rawley Silver **(A)**, who contributed a chapter to *Approaches* (Rubin, 2001), titled her book *Developing Cognitive & Creative Skills through Art* (1978). Silver **(Figure 5.7)** applied the cognitive psychology of Jean Piaget and others to art therapy with the disabled. In 1987, Aina Nucho **(B)** conceptualized a *Psychocybernetic Model of Art Therapy* in which she synthesized cybernetic (feedback) theory with art therapy **(Figure 5.8)** (Nucho, 2003).

Nucho (1995), an art therapist, also wrote a book about *Mental Imagery*,[3] which was an active area in cognitive psychology off and on throughout the 20th century. During the 1970s and 1980s, there were two active national organizations—the American Association for the Study of Mental Imagery whose *Proceedings* are listed in the section titled "Resources" at the back of this book, and the International Imagery Association, which publishes the *Journal*

Figure 5.8 Aina Nucho, psychocybernetic art therapy.

of Mental Imagery. Lusebrink (1990) is another art therapist whose work includes the use of imagery, reflecting her application of such cognitive elements as *information processing* to art therapy.

All of these cognitively based theories of art therapy are, however, quite different from what is currently known as *Cognitive Therapy*. Rosal **(Figure 5.9)** described a *Cognitive-Behavioral* approach, which is more similar to current trends in treatment, in her book (Rosal, 1996) and in a chapter she contributed to the second edition of *Approaches* (Rubin, 2001). Like Rhyne (1995), Rosal **(C)** was also attracted to George Kelly's cognitively based *Personal Construct* theory, using it as a basis for her work in both assessment and therapy.

Figure 5.9 Marcia Rosal, cognitive-behavioral art therapy.

A cognitive approach that has promise for art therapy is that known as the *Solution-Focused* approach, which originated in family therapy based on a *constructivist* approach to therapy (Riley, 1999, 2001; Riley & Malchiodi, 2004). Gilat Gat demonstrated the approach with individual children on a **DVD** (Gat, 2003).

Although she doesn't use that term, the problem-solving approach to nightmares demonstrated by Ann Wiseman with children on the **DVD** is based on a similar kind of thinking **(D)**. The child first draws the nightmare, then tries to think of how it might come out differently, and then redraws it. Her approach to *Nightmare Help* (Wiseman, 1989) is reminiscent of child psychiatrist Richard Gardner's method, the *Mutual Storytelling Technique* (1971), in which the therapist proposes an alternative ending to the story.

Developmental

Closely related to cognitive and behavioral approaches, and often a major component, are approaches that are based on an understanding of growth itself. *Developmental* approaches originated in the work of Viktor Lowenfeld **(E)**, whose *Creative & Mental Growth* has been in print for 60 years (Lowenfeld & Brittain, 1987). Uhlin (1972), a student of Lowenfeld's, based his approach to helping children with disabilities through art therapy largely on what he knew of normal development **(F)**.

Developmental therapy was invented by a special educator whose ideas were combined with those of an art therapist in *Developmental Art Therapy* (Williams & Wood, 1977). Doing art therapy with children who were blind, deaf, and developmentally challenged, led Susan Aach-Feldman **(G)** and Carole Kunkle-Miller **(H)** to adopt a *developmental* orientation, which they described in their chapter in *Approaches* (Rubin, 2001).

Adaptive

The *Adaptive* approach, which works toward *normalization,* was first articulated by Lowenfeld (1957), and was then amplified by Frances Anderson (1992, 1994), an art therapist who has contributed several books on art therapy for youngsters with disabilities and who wrote the commentary on *Psycho-Educational* approaches in the revision of *Approaches* (Rubin, 2001) **(I)**.

Robert Ault (1986) defined two similar orientations as *Process-Centered Art Therapy* and *Product-Centered Art Therapy*, where the focus is on achieving specific goals leading to better and more adaptive functioning. On the **DVD (J)**, you can see and hear Ault's **(Figure 5.10)** brief descriptions of these approaches to art therapy.

In contrast to psychodynamic (analytic) or humanistic approaches to art therapy, those stemming from behavioral, cognitive, or developmental orientations are more likely to offer *prescribed* art activities. While themes or tasks are also offered at times by psychodynamic or humanistic art therapists, they are even more consistently used with behavioral, cognitive, developmental, adaptive, and functional models of treatment. These approaches are also used more frequently in the treatment of individuals with disabilities, who are more likely to require a *remedial* approach.

Systemic Approaches to Art Therapy

Although I had not included group or family art therapy in the first edition of *Approaches to Art Therapy* (because they can be done from so many different theoretical positions), I did decide to add them to the second. This revision (Rubin, 2001) includes a chapter by Katherine Williams (Group) and Barbara Sobol (Family), as well as a commentary by Shirley Riley **(Figure 5.11)**, who did a good deal of work in both family (Riley & Malchiodi, 2004)

Figure 5.10 Robert Ault, process/product-centered art therapy.

Figure 5.11 Shirley Riley, solution-focused art therapy.

and group art therapy (Riley, 1999). Indeed, there are many different schools of thought in both areas.

Most early art therapists were influenced by the dominant psychodynamic thinking about groups, including families. Since then, however, the developing fields of *group dynamics, cybernetics*, and *systems theory* have spawned a whole new set of conceptualizations about people in plural. These ideas have greatly affected contemporary art therapists who work with families (Goldenberg & Goldenberg, 2007) and groups (Yalom & Leszcz, 2005).

Family Art Therapy

One of the most influential art therapy pioneers was Hanna Kwiatkowska, who worked on an inpatient unit for adolescents with schizophrenia at the National Institutes of Mental Health (NIMH), one of the key centers for the development of family therapy itself during the middle of the 20th century. Although other art therapists were seeing families too, this gifted therapist was the undisputed pioneer of *Family Therapy & Evaluation Through Art* (Kwiatkowska, 1978). On the **DVD (5.4)**, you can observe her **(A)** conducting an early **(B)** and a later family art evaluation **(C)**.

Many followed in her footsteps, often learning by observing and consulting with her, like Helen Landgarten **(Figure 5.12)**, who worked in an outpatient clinic for children and families **(D)**. She described work with families in her first book (Landgarten, 1981), and later devoted an entire book to the topic (Landgarten, 1987). Sobol, who was trained by Kwiatkowska at George Washington University, wrote the part of the chapter on family art therapy in the second edition of *Approaches to Art Therapy.* (Rubin, 2001).

Riley **(E)**, who commented on that chapter in *Approaches,* studied art therapy with Landgarten, and later wrote a book titled *Integrative Approaches to Family Art Therapy* (Riley & Malchiodi, 1994). Linesch, a student of both Landgarten and Riley, also edited a book that included a variety of approaches to family art therapy titled *Art Therapy with Families in Crisis* (Linesch, 1993).

Figure 5.12 Helen Landgarten, family art psychotherapy.

As with behavioral and cognitive approaches to art therapy, it would appear that strategic and structural family therapy are not as incompatible with art therapy as they may look at first. What is essential is that—as with any approach to individual art therapy—the clinician needs to have thoroughly mastered the theory, in order to be true to it, as well as to art.

Because of its versatility, art therapy has also been used with many of the possible variations on the family theme, such as couples, multiple family groups, mothers and children, and siblings. Harriet Wadeson (1980), who was trained by Kwiatkowska at NIMH, pioneered in work with couples **(F)** and with groups of families, doing what she called "multi-family art therapy."

Since then, many art therapists have described their work with family groupings of one sort or another (Arrington, 2001; Rubin, 2005a). Lucille Proulx (2002) developed an unusual variation on this theme, inviting parents and their toddlers or preschoolers to work together in groups doing what she called "parent-child dyad art therapy." On the **DVD** you can see her working with one of those groups **(G)**.

Images Illuminate Important Issues—John and His Mother After Father's Death

The following vignette describes work with a 13-year-old boy and his mother at an outpatient clinic where they came for help following his father's death. The mother initiated the referral because, as she said, John had become "unmanageable." In order to assess what was going on and to advise the best modality for treatment, they were first seen individually. Because they had each described problems between them, I suggested that they come in for a joint art session.

I first asked John and his mom to draw a picture together. Although they discussed it in advance, and tried at first to create a joint picture, they ended up dividing the paper in half, each drawing his or her own version of their jointly selected theme: "Our House" **(H)**. When they were done, they were astonished at how different their representations of that same home were. John's house had "dark clouds over it," while his mother's looked quite cheerful. They decided that they often perceived the same thing quite differently, and agreed that this was one of their main problems in communication and in getting along. John then became tearful about how he felt his mom not only misunderstood, but also rejected him. I observed that his mother had as hard a time hearing what he was saying as she had in seeing what he had drawn.

At a second joint session, I asked each to draw a portrait of the other, on opposite sides of the table easel, which each individual then "corrected" **(I)**. John felt that his mother had portrayed him as older than he really was, sensing her very real wish to have him replace his father—to be "the man of the house"—while at the same time complaining about his assuming an adult role. Mother thought John had made her eyes and mouth "too large and sexy" **(J)**. After modifying the features, she added a "more attractive" hairstyle and more appropriate earrings. In fact, she had made the drawing even more seductive, while at the same time speaking to John in a critical, distancing fashion.

This confusing message, echoing her adolescent son's own (normal) revived oedipal wishes, was causing tremendous anxiety in both. Mother described John as "putting up a wall" between them, while he felt that she was "holding me on a leash" and treating him "like a baby" **(K)**. Both were eventually treated in family art therapy, which turned out to be a modality that helped them to see and hear each other better.

Two recent publications on work with families in art offer a good overview of some of the different approaches developed by early workers in this area. The first (Arrington, 2001) has useful charts comparing family art evaluations. The second is a multi-authored volume

by members of the next generation of art therapists, who explain the various systems and schools of family therapy, providing a useful overview of this domain (Kerr, Hoshino, Sutherland, Parashak, & McCarley, 2008).

Group Art Therapy

There is a similar variety of theories and techniques in group art therapy, but no individual has had a dominant role comparable to Kwiatkowska's with families. It is likely that more patients experience art therapy in a group than in any other context, which has probably been true from the inception of the discipline.

A truly *open* studio in the literal sense of a place that patients could visit when they wished was initially most common in the 1940s for people like Mary Huntoon at the Winter Park Veterans Administration Hospital in Topeka, Kansas, Edward Adamson at the Netherne Hospital in Surrey, England **(L)**, and E. M. Lyddiatt at a number of British hospitals. Although there was more than one person in the room at a time, each worked quite independently.

As time went on, with the growing understanding of group dynamics (Bion, 1991), the trend has been toward approaches that more consciously utilize the power of the group in conjunction with the power of art. Art therapy students often learn about *group dynamics* and *group process* through participating in art groups themselves (Ulman & Dachinger, 1975). Over time, many approaches to group art therapy have been described by different clinicians, working with both children and adults.

One of the first books on the topic, by art therapist Cliff Joseph **(M)** and psychiatrist Jay Harris, was *Murals of the Mind* (Harris & Joseph, 1973). Like most early publications, it was psychoanalytic in orientation. Because of the method (all patients working together on a mural), it is a fascinating study of an inpatient group's development over the course of a year, by analyzing the form and content of weekly murals.

Though the practice of group art therapy gradually expanded during the growth of the field in the 1960s and 1970s, there were few publications. They more than doubled, however, between 1975 and 1980. Gestalt and humanistic approaches became increasingly common. Janie Rhyne's book, first published in 1974, devoted an entire section to work with groups, and several others included chapters on that modality (Landgarten, 1981; Rubin, 2005b; Wadeson, 1980). The work described by Xenia Lucas in her 1980 book was typical of early group art therapy. Although group process was acknowledged, the primary focus was on individuals and their artistic and psychological development.

When Kathleen Hanes compiled an annotated bibliography called *Art Therapy & Group Work* in 1982, she noted that art was being offered in groups that ranged from unstructured "open studio" situations to theme-centered ones and those using interactional tasks. She also reported that the emphasis was intrapsychic as often as it was interpersonal, but that interventions based upon group dynamics were increasing.

Meanwhile, our art therapy colleagues in Great Britain also found themselves often working with groups. In 1941 Dr. Joshua Bierer, who developed *Adlerian social clubs* in London, invited artist Rita Simon to work with his patients in groups, initiating her long career in art therapy. In 1986, Marian Liebmann published a survey of techniques used in group art therapy, which offered practical advice along with many exercises. Others have continued that tradition, proposing group art activities with some sort of structure (Campbell, 1993; Fausek, 1997; Furrer, 1982; Makin, 1999).

Liebmann's book provoked a debate in the United Kingdom regarding the wisdom of structured as opposed to unstructured approaches. It seems to have been especially

heated, due to the importance there of the "group analytic" tradition. That in turn was based in part on the work of British psychoanalyst Wilfred Bion (1961), the foundation of what is known as the *Tavistock method* of learning about group dynamics by participating in an unstructured group in which the consultants relate only to the group, not to individuals.

Katherine Williams, who wrote about group art therapy in the second edition of *Approaches* (Rubin, 2001), was trained in that model. In 1993 Diane Waller described her model of *group interactive art therapy*, based on concepts derived from group analysis, interpersonal group therapy, systems theory, and art therapy. Waller and several of her colleagues have been trained at the Institute of Group Analysis, enabling them to synthesize what they know about art therapy with what they know about analytic groups. (McNeilly, 2006; Skaife & Huet, 1998)

Interpersonal group therapy, as presented in the widely used books by existential psychiatrist Irvin Yalom, has been popular in both countries and dominant in the United States (Yalom & Leszcz, 2005). Many art therapists work with groups, but few have had formal training in group psychotherapy.

Perhaps because she was a sophisticated family art therapist and the family is, after all, the first group, Shirley Riley's (2001) work in group art therapy is equally thoughtful: "group process made visible." Change in a group can be seen as members develop trust and the group takes on shape and definition as an entity in its own right, becoming more cohesive. In this context, the individuals in group treatment also change, as they utilize the resources in art and each other to work on and solve their conflicts.

The following vignette indicates how much even a brief art therapy group can help one of its members to begin to change and to grow. Members were free to use whatever materials they wished and to make whatever they wanted. After the working time, the group gathered around a table for snacks and discussion.

Individual Growth in a Group: DON (9)

In the first few meetings of a short-term art therapy group of latency-age boys, nine-year-old Don worked apart from the others, drawing compulsively tight abstract designs **(N)**. Gradually, however, he began to interact with the other boys. At first he sat closer to them, but he was still silent. His designs, however, became somewhat freer, and he began to use various kinds of paint, to explore color mixing, and to allow himself a greater range. Stimulated by the other boys, Don then turned to the more tactile and regressive medium of clay. At first he made tame animals, like dogs and cats. Then he made larger and more aggressive ones, like dinosaurs and lions.

Eventually, he was able to model a boy who had been violently wounded, painting red blood streaming out of his maimed body **(O)**. Although Don wouldn't say who it was, the following week he whispered to me that he knew, but was afraid to tell the others. I asked if he could tell me, and he whispered, "my brother." I suggested that it might help the other boys in the group, many of whom had similar angry feelings and wishes toward siblings, to know that they were not alone.

During group discussion time at the end of the session, Don tentatively whispered that it was "somebody younger," then "somebody I'd like to throw something at," and finally, "my brother." The others responded with relief, and an outpouring of their own impulses to hurt younger siblings, along with fears of their strength and destructiveness.

Don was delighted, and responded the following week by becoming uncharacteristically messy, smearing and mixing tempera paint colors with another boy, for the first time

allowing himself to interact playfully with other group members. His products for the next two weeks were not much to look at **(P)**, but the process he engaged in was vital to his eventual recovery. He followed this aggressive/regressive phase with a freer kind of order in his work.

After the eight-week group had ended, Don continued in individual art therapy for several months. When he terminated treatment, he selected a tempera painting with movement, color mixing, and clear-but-not-rigid boundaries as a gift for his therapist **(Q)**. It reflected the integration of freedom and order that he had been able to achieve internally as well.

Art/Image-Based Approaches to Art Therapy (DVD 5.5)

All art therapists share the common ground of *art*. Some have tried to apply aesthetics to assessment as well as to treatment. Rita Simon (1992, 1997) developed a theory based on the formal elements of graphic style. Simon analyzed *style* as *archaic, linear, traditional*, and *massive*, suggesting a unique way to look at pictures, which served the author well in both diagnosis and in therapy. For her it was a coherent and useful system.

Creative analysis was developed by psychologist Ernest Zierer and art therapist Edith Zierer. Although presumably based on psychoanalytic ego psychology, it was unusual for an analytic approach in that there were many specific interventions. The art therapist chose, from among a number of possible artistic tasks, those considered most appropriate for each patient, for the purpose of diagnosis as well as for therapy. Looking at the *form* rather than the *content* of the oil paintings created in their studio, the Zierers assessed the degree of *color integration* in the artwork. This was thought to reflect mental health, while its absence (*color disintegration)* was seen as reflecting mental disorganization or disturbance. Both the Zierers and Simon focused on what they could learn from the art and used their idiosyncratic systems during long careers in art therapy.

There are other more communicable approaches to art therapy that emphasize the *art* or—as some prefer—the *image*. Art-centered theories usually stress either the creative process, the visual imagery that results from it, or both. Since art itself is theory free, these approaches are compatible with a wide variety of theoretical orientations, including Freudian (Lachman-Chapin, 1994; Robbins, 1987, 1989), Jungian (Wallace, 1990), Gestalt (Rhyne, 1995), Cognitive (Lusebrink, 1990), Phenomenological (Betensky, 1995), and Existential (Moon, 1995, 1996).

Pat Allen (1995) focused on the power of art to create meaning in *Art Is a Way of Knowing* **(A)**; Shaun McNiff (1994) stressed its healing potency in *Art as Medicine* **(B)**. As noted earlier, the return to the art studio has brought a renewed interest in art and the image as the core of our work, with a renewal of *studio art therapy* approaches (C. H. Moon, 2002). Cathy Moon **(C)**, author of a book by that name, is currently the chair of the art therapy master's degree program at the Art Institute of Chicago, founded by Don Seiden **(D)**, who published his *Artobiography* in 2006. It is perhaps the most rapidly growing orientation within the United States and is often linked with the other prominent trend, that of *spiritual* approaches. Like with art- or studio-based approaches, its proponents come from a wide variety of theoretical orientations.

Spiritual Approaches to Art Therapy

A strong current in contemporary American art therapy has to do with the spiritual aspect of our work. Shaun McNiff, for example, wrote a book about inanimate objects as *Earth*

Angels (1995). Jung, the son of a minister, valued the spiritual elements in psychoanalysis, whereas Freud, the rationalist, was determined to prove the scientific nature of the new depth psychology.

Ironically, both polarities are more important in the mental health domain than ever before. *Psychobiological* approaches currently dominate the field of psychiatry, while *neuroscience* and *cognitive-behavioral therapy* dominate contemporary psychology. At the same time, in a technological world where human values often seem to have been lost, the hunger for meaning has been intensified. One reflection of this longing is the popularity of spiritual approaches in mental health, as in the many kinds of treatment programs based upon the *twelve-step* method of overcoming addiction, which has been adopted by art therapists as well (Chickerneo, 1993; Waller & Mahony, 1999).

Art therapy, drawing as art has from time immemorial on the human spirit, offers a most appealing avenue for authentic expressions of the soul. Even the most rational among us knows of the deep inner well from which we draw when we express ourselves. While I have found a psychoanalytic orientation most useful in my own work, it does not seem incompatible with the title I used for a book addressed to the general public: *Soul Prints* **(DVD 5.6)**.

Even though art therapists operate from a number of different perspectives, one that cuts across all of our theoretical differences is that of the human spirit, which is so essential to our creative capacity. The philosophy of *anthroposophy*, which underlies the work of Rudolf Steiner and his followers, while primarily expressed in the educational arena of the Waldorf Schools, has also spawned a somewhat mystical approach to *color therapy* (Collot d'Herbois, 1993) and *painting therapy* (Hauschka, 1985). It remains extremely popular in Germany.

Spirituality is a strong element in Bruce Moon's work, for example, *Art & Soul* (1996), and Ellen Horovitz **(Figure 5.13)** has published a series of books with titles like *Spiritual Art Therapy* (2002b), *A Leap of Faith* (1999), *Art Therapy as Witness: A Sacred Guide* (2005), and has created the *Belief Art Therapy Assessment* (2002a**) (A)**. Spirituality is also central in *transpersonal* approaches to art therapy, so it is not surprising that Pat Allen has also written a book called *Art as a Spiritual Path* (2005). And Lynn Kapitan **(B)** has addressed a need

Figure 5.13 Ellen Horovitz, spiritual art therapy.

she has called *The Re-Enchantment of Art Therapy* (2003), which has a similar kind of plea for poetry.

The most multifaceted compendium of such approaches is found in Mimi Farrelly-Hansen's (2001) edited book, *Spirituality & Art Therapy.* David Henley (2002) subtitled his book on using clay *Plying the Sacred Circle,* and Paolo Knill and his colleagues (2004) called their most recent explanation of an intermodal approach *Minstrels of the Soul.* Just as humanistic approaches were a reaction to the dominance of psychodynamic ones, so the move toward both studio and spiritual approaches is in part a reaction to what Allen (1995) called the "clinification of art therapy."

Integrative Approaches to Art Therapy

In the 2001 revision of *Approaches to Art Therapy* I grouped approaches that integrated one or more theoretical perspectives **(DVD 5.7)**. Two chapters from the first edition dealt honestly with the many determinants of theoretical positions and technical decisions, each articulating a rationale for adopting more than one model to guide work in art therapy. Ulman **(A)** explained how and why she ended up working with some patients in *art as therapy* (Kramer) and with some using *art psychotherapy* (Naumburg). Wadeson **(B)** described her *Eclectic* approach, how it evolved, and how she used it over the course of a long career **(Figure 5.14)**. Both offered intelligent considerations of how to be open-minded without being sloppy.

By the time the second edition was published, *Multimodal* theorizing as well as methods had become much more common, so two new chapters were added to this section. One is by Shaun McNiff (**C**) (1986), who had founded a training program in *expressive therapies* in 1974 at Lesley (**Figure 5.15**). McNiff's chapter dealt with a way of working with groups in art using the imagination as well as multiple modalities (McNiff, 1998b, 2003). The other,

Figure 5.14 Harriet Wadeson, eclectic art therapy.

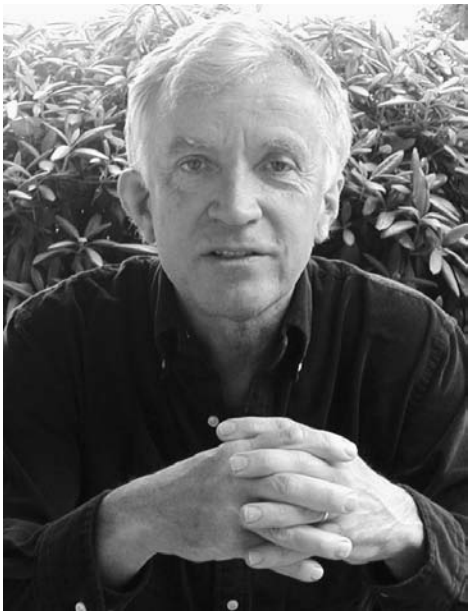

Figure 5.15 Shaun McNiff, expressive therapies.

by David Henley (**D**) (2002), described work in a class of disturbed adolescents not only in more than one art form, but also integrating psychoanalytic concepts with cognitive and behavioral ones. Natalie Rogers's (**E**) chapter integrating person-centered therapy with different art modalities in the humanistic section could equally well have been in the integrative one.

All of the chapters in this section of *Approaches* exemplify what I believe Bernard Levy meant when he wrote, "While divergent viewpoints can be 'integrated' as a conceptual act and even rationalized with an eclectic philosophy, the rationale must not be so broad as to espouse laissez-faire. Integration of divergence need not mean that 'anything goes.'"

Theory, Technique, and Art Therapy

Art Therapists as Theorists

Art therapists are attracted to the field because they like both art and people, and they tend to be curious as well as compassionate and creative. For some, the curiosity extends beyond wanting to understand the people they see and the art that is created, to the creative process that seems to work so well in psychotherapy. This very combination can make theory building endlessly fascinating. Since in many ways art therapy is "a technique in search of a theory" (Rubin, 2005a), it has been fortunate for the field that these restless minds loved to explore new ideas in relation to art therapy **(DVD 5.8)**.

Thus, Margaret Naumburg (1966) in her later years was busy reading *archeologist* Siegfried Gideon and applying his findings to art therapy **(A)**. Edith Kramer (2000) wrote extensively about the implications of Konrad Lorenz's work in *ethology* for art therapy **(B)**. Joy Schaverien (1995) used *anthropology* to amplify her understanding, offering us new ways to think about familiar phenomena, like the art as a *talisman* or a *scapegoat*. All art therapists who have worked out ways of applying different theoretical constructs have done so by

synthesizing what they knew about the therapeutic power of art with what they understood about one or more theories of psychotherapy.

The Unspoken Perspective

Theoretical ideas and the techniques that follow therefrom continually evolve and change in all forms of treatment, including art therapy. As with clinicians who help through words, the majority of art therapists don't think of themselves as following any particular theoretical model. Yet like talk therapists, all art therapists have some notions of what is amiss and how to help people to get better. These ideas necessarily underlie what they do and the way they do it. Though it may remain unarticulated, there is always some kind of unspoken theory behind any art therapist's technique.

Any clinician's preferred theoretical approach is likely to be chosen for largely personal reasons. These include those by whom she has been trained and with whom she has identified, as well as those with whom she works. In addition to experiential variables, temperament is another reason for choosing a preferred framework. The approach selected may be pure or mixed, rigid or flexible. Hopefully, it is both clear and consistent.

Selective Eclecticism

Although it is essential to have a solid grounding in some coherent notion of how people function and how to help them to get better, most clinicians are not purists. In fact, most art therapists are probably mainly *pragmatic,* selecting the approach that best fits the particular situation. Robert Ault (1986), who wrote the commentary on the integrative section for the revision of *Approaches,* described three different approaches, each one to be utilized depending on the needs of the patient(s). He called them *person-, process-, and product-centered art therapy* **(C)** (Ault, 1986).

As Helen Landgarten said, "The truth of the matter is that art therapy is not a discipline, it's … a modality. Art therapy is a way of getting there. *It operates as a modality because you can adapt it to any theory.*[4]

Is Theory Really Necessary?

But what about the art therapist who rejects theory? Isn't it possible to simply be a sensitive person and to be a good therapist as well? There is a difference of opinion in art therapy, as in other clinical disciplines. An *intuitive* approach is probably more acceptable in art therapy, because artists pride themselves on their innate sensitivities, and tend to be anti-authoritarian and anti-theoretical. It seems a logical continuation of the romantic, bohemian tradition, which is appealing to creative people.

Art therapists, however, usually do their work not in artists' lofts, but in offices and institutions run by others. The art therapist is responsible for meeting the goals for which she is being paid, whether she is employed by educators, health professionals, or patients. For an art therapist in private practice, there is an even greater sense of responsibility, because, in truth, the patient's life is in her hands.

Art is a wonderful modality. It has the power to cut through defenses and to uncover unconscious material quite rapidly. It is also a very exciting modality, with the power to stimulate a regression which—in those whose defenses are too fragile—may need to be contained. An art therapist needs to know what she is doing, especially when people are in a vulnerable state.

Most people who come to art therapy, even the "worried well" who are not grossly disturbed, can still be injured by naive or tactless work. Without some understanding of human

frailties and the terrific complexity of mental functioning, as well as the delicacy of healing, I believe that even the most well-intentioned artist is in danger of violating the oath taken by physician healers, which is to *do no harm*.

For this reason, art therapists in training are familiarized with many theories of psychology, psychopathology, and psychotherapy. And they are required to work under close supervision for a substantial period of time before being eligible for registration, in order to be sure that they have assistance in the difficult task of translating theory into practice.

Theory is what enables any therapist to make sense of the data being received, and to be thoughtful about technique. Only with a coherent perspective on what she does can the art therapist make fully available the healing powers of art. In fact, it is only when she has truly mastered some theory of psychological functioning and of psychotherapy, when it is "in her bones," that she can use her intuition in the most helpful way. Theory helps an art therapist to sharpen both her thinking and her clinical skills.

Since art therapy does have connections with other disciplines, it makes sense in theory, as elsewhere, to utilize any relevant insights to understand why and how art therapy works. It seems as unnecessary to throw the baby out with the bathwater as it would be to reinvent the wheel. Just as those metaphors remind art therapists that they can learn from others, so the notion that "a picture is worth a thousand words" is one of the reasons art therapy works. Effectively integrating the synthesis of art and therapy requires an internalized frame of reference.

The more extensive an art therapist's understanding of different approaches, the more clinical lenses she has with which to see (Hedges, 1983). Like a stain on a microscopic slide, a theory can enable a therapist to literally *see* something that would otherwise be invisible. And if she can look at a problem from a different angle, she is often able to view possible solutions from a new perspective. It is a kind of *reframing* for the therapist, for whom a cup can look either half-empty or half-full, just as it can for the patient. That is probably why so many have struggled with the difficult questions of how to view, understand, and do art therapy—in order to help the people they serve as much as possible through art.

Endnotes

1. Harms, E. (1973). "Editorial: Provinces and Boundaries of Art Psychotherapy." *Art Psychotherapy,* Vol. 1, No. 2, p. 1.
2. Maslow, A. "Creativity in Self-Actualizing People." In *Creativity and its Cultivation*, edited by H. H. Anderson. New York: Harper and Row, 1959, pp. 83–95.
3. The reader should not assume that an interest in mental imagery is restricted to those favoring cognitive therapies. My analytic institute graduation paper dealt with spontaneous visual imagery in adult and child analysis, and I included a chapter about its use in *Artful Therapy* (Rubin, 2005b).
4. From "An Interview: Helen B. Landgarten, by L. A. Warren, 1995, *American Journal of Art Therapy, 34*, p. 36, emphasis added.

CHAPTER 6

Assessment

The use of any combination of verbal, written, and art tasks chosen by the professional art therapist to assess the individual's level of functioning, problem areas, strengths, and treatment objectives.

American Art Therapy Association, *General Standards of Practice*

Art and Diagnosis

It has already been noted that some of the threads that became part of the fabric of art therapy came from wanting to understand people through their art expression. The goal may be to identify exactly what is wrong, or to get to know the person better in a more general way. Even when a diagnostic label is not the purpose of an assessment, finding out where an individual is on any dimension relevant to treatment can be extremely helpful. Just as there are many different ways of classifying the information obtained, so there are also multiple methods of gathering data using visual means. This chapter will offer an overview of the many ways of understanding people through art as they have evolved over time.

Projective Techniques

As noted in Chapter 3, *projective testing*—both responsive and expressive—flowered in clinical psychology for several decades, especially during the 20th century. Although no longer as widely used, its history is relevant because the many variations developed over the years greatly influenced the training and work of art therapists. Like most early theories underlying art therapy, it was based on the work of analysts regarding the universal human need to project (or find) meaning in the world.

The assumption behind all such approaches is that the individual is revealing important information that—because it is unconscious and therefore unknown—is not accessible in more direct ways. This is true whether a person is responding to some kind of visual stimulus with his ideas, or is creating something himself using art materials. Psychologist Lawrence Frank termed this the "projective hypothesis."[1] On the **DVD (6.1)**, psychologist

Bernard I. Levy is teaching an art therapy class and then a group of psychiatry residents at Walter Reed about projective techniques.

Responding to Visual Stimuli

In some approaches, the individual is asked to give meaning to a series of stimuli. They may be abstract, like the famous inkblots introduced by psychoanalyst Hermann Rorschach in 1921 (cf. Exner, 2002) or the molded shapes of Twitchell-Allen's (1958) Three-Dimensional Apperception Test. They may also be representational, like the drawings of people in Murray's Thematic Apperception Test (TAT), or of animals in Bellak's version for children, the Children's Apperception Test (CAT). Some tools are specific to the problem, like the *Storytelling Card Game* (R. Gardner, 1988).

Preference Tests

In these, the person chooses from among visual stimuli. Some involve color, as in the Luscher Color Test (Luscher, 1969). Others involve design, like the Welsh Figure Preference Test (Welsh, 1959), which asked people to select preferred line drawings. This test included the *Barron-Welsh Art Scale* developed with Frank Barron, a psychologist specializing in creativity who later advised art therapist Janie Rhyne on her doctoral dissertation. Rhyne (1995) asked individuals not to *respond* to, but to *create* line drawings representing a series of affective states.

Art therapist Joan Kellogg's **(Figure 6.1)** studies of recurring patterns in mandala drawings were the basis for her selection procedure, the *MARI Card Test*, which involves both color and design (Kellogg, 1980). For her doctoral research, art therapist Doris Arrington **(Figure 6.2)** (2005) created a *Visual Preference Test*, in which participants select and rank line drawings. Like the images seen in inkblots or stories told about drawings, such choices are assumed to reflect fairly stable aspects of personality. On the **DVD (6.2)**, art therapist Carol Cox, one of Kellogg's colleagues, administers a MARI test, which includes both the creation of a mandala and an active response to a set of carefully designed cards.

Figure 6.1 Joan Kellogg, MARI Card Test.

Figure 6.2 Doris Arrington, Visual Preference Test (VPT).

Copying and Completion

Used in art education for centuries, copying has also been helpful in the psychological assessment of organic impairment, as in the *Bender Visual-Motor Gestalt Test* (Bender, 1952). Completion procedures are another popular approach. In the *Kinget Drawing Completion Test*, for example, each of the eight sections on the test blank contains a dot or a line, which the subject is invited to develop into a picture (Kinget, 1952). This kind of standardized ambiguous stimulus is similar to the chosen or created stimuli suggested by art therapists as "starters," and is used in treatment as well as in assessment.

The Scribble Drawing

At about the same time, a playful British analyst named Winnicott **(Figure 6.3)** and an inspired American art teacher named Cane independently came up with the notion of using a scribble as a visual starter; that is, developing a picture from a self-made scribble. For Winnicott, it provided a rapid and nonthreatening way to get to know a child he was assessing; and because his interest was in communication rather than composition, a pencil and a small piece of paper suited his *Squiggle Game* (Winnicott, 1964–68; 1971b). Cane, on the other hand, wanted to stimulate freedom and spontaneity in art expression, so her *scribble* technique included preparatory breathing and movement exercises (**Figure 6.4**), and was done on large drawing paper with colored pastels (Cane, 1951). On the **DVD** you will see Elinor Ulman demonstrating the technique as part of an assessment (**DVD 6.3**).

Taught by Cane's sister Margaret Naumburg (1966), the scribble remains extremely popular among art therapists. It was incorporated into the first formally designed art therapy assessment batteries for both individuals (Ulman & Dachinger, 1975) and families (Kwiatkowska, 1978). Since young children have difficulty with the task, Ron Hays proposed a Dot-to-Dot drawing as an alternative for them (AATA *Conference Proceedings,* 1979). Many other "visual starter" approaches are used in treatment as well as diagnosis, some of which are noted in the following chapter.

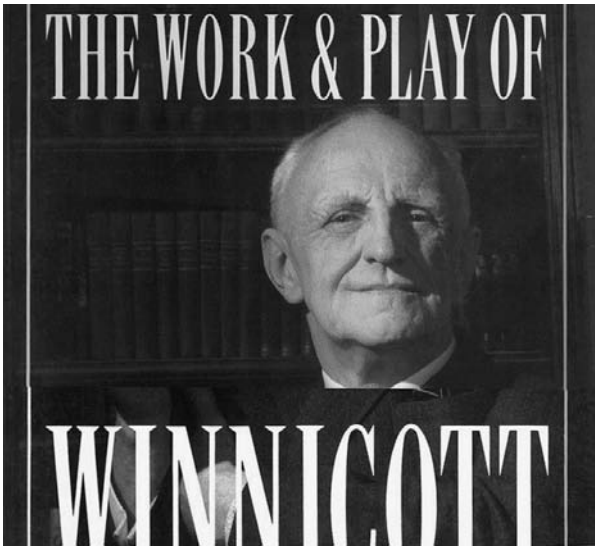

Figure 6.3 Donald W. Winnicott, Squiggle Game.

Projective Drawings

The first individual to standardize procedures for using drawing tests with patients was a German psychiatrist named Fritz Mohr in 1906 (Malchiodi, 1998). Using children's drawings of a person to measure intellectual development was pioneered by a child psychologist in 1926 as the *Draw-a-Man Test* (Goodenough, 1926). In 1931, a psychiatrist named Kenneth Appel[2] (who commented on one of Naumburg's early published cases) described an extensive "drawing battery" he was using in his initial interviews with children, which included drawing human figures.

Clinical psychologist Karen Machover noticed that many features of person drawings seemed to be dynamically significant, so she included the task in her assessments. In 1949 she published a book describing a number of "signs" and their presumed meaning in her *Draw-a-Person Test* (DAP) (Machover, 1949). Psychologist John Buck also saw meanings in the drawings on IQ tests, and in 1948 he introduced his House-Tree-Person Test (H-T-P),[3] in which all three topics were part of the task. His hypothesis was that the house and tree drawings were also self-projections, but less obvious and therefore potentially more revealing.

Central to projective drawing analysis is the assumption that formal elements—like placement, line quality, or shading—are as significant as subject matter. Since many early art therapists were trained by clinical psychologists during the heyday of projective drawings, they incorporated them into their own work and taught their students (Drachnik, 1995). Most art therapists no longer rely on the projective drawing tasks still used by some clinical psychologists, due to a literature that has demonstrated their lack of validity. In learning from people's artwork, however, art therapists also consider form as well as content.

An emphasis on form is the basis for art therapist Linda Gantt's development of the *Formal Elements Art Therapy Scale,* a rating manual for drawings of a *Person Picking an Apple From a Tree (PPAT),* a topic first used by art educator Viktor Lowenfeld (1957) to stimulate the child's identification with the activity being represented **(DVD 6.4)**. Indeed, most art therapy assessments have incorporated psychological testing's demand for standardized

Figure 6.4 Florence Cane teaching a class.

administration of tasks (including the materials being offered) and for scales that result in inter-rater reliability.

In 1958, when projective techniques were being used and created by many, clinical psychologist Emanuel Hammer (1958) edited *Projective Drawings,* in which Naumburg described the history of art therapy and presented a case study. She also noted some of the similarities and differences between prompted, standardized, projective drawings, and the spontaneous work created in art therapy that are still valid (cf. also Hammer, 1997).

Despite numerous research studies, in which most of the common assumptions about the meanings of various "signs" could not be validated, projective drawings have remained popular among some clinical psychologists (Liebowitz, 1999; Oster & Crone, 2004; Oster & Montgomery, 1996) and some art therapists (Brooke, 2004). This is probably due to their ease of administration, as well as the richness of material obtained. Many inventive ideas have been proposed by individual clinicians over the years.

Some involved alterations of some sort (Hammer, 1958). Rosenberg, for example, offered the freedom to *change* completed drawings (of a man and a woman) in any way, using a carbon copy for comparison. Caligor went further with the Eight-Figure Redrawing Test,

in which the person made a *series of eight drawings* of the human figure, each one based on the previous one—as seen through a sheet of onionskin. The instructions were: "Change it in any way you like."

Perhaps inspired by such tasks, art therapist Harriet Wadeson used a similar technique with couples. She invited both members of the pair to draw a portrait of the other, after which each had an opportunity to modify their partner's picture as they wished (Wadeson, 1980). Robert Ault also included such a task in his assessment battery for couples, to be described later. On the **DVD** you can observe Wadeson instructing a couple in how to do this task **(DVD 6.5)**.

Variations on drawing themes have been extensive. These include other self-representations, like a tree, a house, or animals. Sometimes the topic is designed to evaluate the person's ability to cope with stress, such as drawing "a person in the rain" or the Most Unpleasant Concept Test—"draw the most unpleasant thing imaginable." References to such efforts can be found in the books by clinical psychologists (Hammer, 1958, 1997; Oster & Montgomery, 1996; Oster & Crone, 2004) and by art therapists (Brooke, 2004; Malchiodi, 1998a; Rubin, 2005b).

Though many other topics have been proposed, the drawing of the *Human Figure*—or its symbolic extension in the *House-Tree-Person* test—remain the most popular themes with the majority of clinicians, including many art therapists. The H-T-P is either done with a pencil (achromatic) or a set of eight crayons (chromatic). Along with the hypothesis that an individual projects core personality traits in drawing behavior, there is also the related assumption of an internal schema, the *body image*. This idea, originated by psychiatrist Paul Schilder (1950), is one reason for the continuing popularity of the person drawing and other themes that, like the tree or house, are assumed to also represent an individual's sense of himself.

Its only close competitor, clearly superior for getting a picture of the interpersonal situation, is the *Family Drawing*, described in 1931 by psychiatrist Kenneth Appel (see footnote 2, this chapter). Appel suggested adding activity, an idea later popularized by Burns and Kaufman (1970) in the widely used *Kinetic Family Drawing* (KFD). The instructions are: "Draw a picture of everyone in your family, including you, doing something." Burns went on to suggest other ideas, like the Kinetic House-Tree-Person Drawing (Burns, 1987) and the Family-Centered Circle Drawing (Burns, 1990).

One of the variations on the family drawing theme proposed in Burns's 1990 book was called the *Parents' Self-Centered Circle Drawing*. In 1970, art therapists Selwyn and Irene Dewdney asked some of their patients to draw a *mother and child* (Ulman & Levy, 1981). In 1994, psychologist Jacqueline Gillespie suggested the diagnostic use of *Mother-and-Child Drawings*. Since I had been asked to review that book, I tried the task with several adult patients, whose mother-and-child representations were surprisingly helpful in their therapy.

Although the family is the first and most dynamically significant group, others become increasingly important in the course of normal development. In the 1940s the inventor of psychodrama, Jacob Moreno, suggested making pictorial diagrams of interpersonal relationships, with names like *Social Atom* and *Sociogram*.

The latter is used in teaching art therapists by Charles Anderson, who was trained during an era when projective drawings were extremely popular. In his classes, Anderson advised the use of such techniques because, given the time pressures in contemporary mental health, they are very rapid ways of gathering useful information (Anderson, 2000, 2003). These methods are quite similar to the *Genogram*, which is popular among family therapists (McGoldrick & Gerson, 1985; Kerr et al., 2008). Anderson can be seen on the **DVD**, teaching the *Sociogram* to his students **(DVD 6.6)**.

In 1974 Prout and Phillips[4] proposed a *Kinetic School Drawing* (KSD), to be done following a KFD. Klepsch asked children to draw a classroom and to do portraits of authority figures—teacher, doctor, policeman—to assess a youngster's sense of himself in relation to others. Following in the footsteps of Wayne Dennis, who studied *group values through children's drawings*, he reviewed other such studies (Klepsch & Logie, 1982).

Standardization in Drawing Tasks

Most projective drawing tasks developed by psychologists use standardized materials—usually 8" x 11" paper, a No. 2 pencil, and when "chromatic," specific colors and types of crayons. Instructions for each of the drawings are also clearly specified, as are the guidelines for any post-drawing interrogation (PDI). Such standardization is needed to establish group norms, to which clinicians can then relate individual performance. Like norms, precise scoring methods are also needed. For example, one version of the Draw-a-Person Test used *templates*, in an attempt to more objectively measure size and placement.

A systematic approach to test administration, clear identification of items to be scored, and the creation of rating manuals are tedious but necessary steps on the road to *reliability*. One aspect is *test-retest reliability*—how consistent anyone's performance is on a particular instrument. The other is *inter-rater reliability*—how similar raters' judgments are with any specific scale. Whether the instrument measures what it is supposed to—*validity*—is another heavily debated issue. It is the source of most of the criticism leveled at all projective techniques, especially drawings.

Nevertheless, despite negative findings in all of the experimental research, projective drawings did and still do appeal to clinicians from many disciplines. One of the most prolific writers in this area was a pediatrician named Joseph Di Leo, who published a series of books on children's drawings (1970, 1974, 1977, 1983). Di Leo's goal was a differential diagnosis of "the unusual and the deviant" in the context of "the usual and the normative." His diagnostic battery included both copying tasks and specific topics and was popular among some art therapists working with children, as he published during a period of rapid growth in the profession.

Art and Psychopathology

In the early 1970s, a group of clinicians published *Human Figure Drawings in Adolescence*, using pictures collected at a medical clinic (Schildkrout, Shenker, & Sonnenblick, 1972). The idea was that drawings could be efficient screening devices for potential psychiatric problems. Considerable attention was given to signs of emotional disturbance, of organicity, and of danger, that is, "acting-out" of any sort, especially suicide or homicide. The search for warning signs in artwork, whether in a prescribed task or in spontaneous products, can be critical, especially in acute psychiatric settings or in the criminal justice system. Art therapists and others have long sought to identify graphic clues to a variety of diagnostic puzzles (Cohen & Cox, 1995; Gantt & Tabone, 1998).

Most of the early projective drawing literature—like art therapist Brown's (1967) *Psycho-Iconography* or psychologist McElhaney's (1969) book on human figure drawings (HFDs)—was an attempt to familiarize clinicians with typical drawing signs in patients with different disorders. "Art as a Reflection of Mental Status" was the title of psychiatrist Paul Fink's contribution to the first issue of *Art Psychotherapy* in 1973. In fact, there are many ways in which art products can help in differential diagnosis. But it is far from simple, as experienced art therapists, psychologists, and psychiatrists know. Research attempts to validate the meanings of individual drawing *signs*—like shading indicating anxiety—have found them to be less successful than *global ratings*.

Two psychologist/art therapist teams designed similar studies in the late 1960s, independent of one another. Each asked the simple question of whether individuals could judge psychopathology from spontaneous art. Could they tell which picture was done by a patient and which was done by a nonpatient? The judges in a study using adult paintings (Ulman & Dachinger, 1975) were more successful than those in one using child art products (Rubin, 2005a). Although in neither case was success related to years of clinical experience, a subsequent study suggested that training art therapists to assess artwork by adult patients could increase their accuracy (Ulman & Levy, 1981).

Art therapist researchers have questioned most generalizations about patient art. Even though art therapists consult that literature, they tend to be nondogmatic, largely because of the impact of their direct experience. Wadeson, working at the National Institutes of Mental Health (NIMH), designed a series of studies to identify the characteristics of pictures by people with various disorders, which she summarized in her first book (1980). In addition to trying to be precise and descriptive, Wadeson sought a *phenomenological* understanding of a patient's experience. She asked for drawings such as: a self-portrait, what it was like to be depressed **(Figure 6.5)**, to have delusions or hallucinations, or to be in a locked space. Like many art therapists, she often included a free drawing in her assessment battery.

Figure 6.5 "Corridor of Loneliness" by a depressed patient.

Studies of Artistic Development

In the area of developmental psychology, interest in children's drawings waxed and waned in the course of the 20th century. During the child study movement at the turn of the century, drawing studies tended to be either collections of work done by large numbers of youngsters, or detailed longitudinal observations of an individual child, sometimes including the drawing process as well as the products. (See Rubin, 2005a for references.)

However, during the last quarter of the 20th century, developmental psychologists were busy once again studying children's spontaneous art expression. This is due not to a fascination with art, but to an interest in the growth of cognition—and an awareness that drawing behavior is a useful index. That focus on the study of children's drawing behavior was inspired in part by the work of psychologist Rudolf Arnheim (1954), an early supporter of art therapy.

One of Arnheim's students, Claire Golomb, did some of the best research on the development of children's art. In 1974 she published inventive studies of young children's development in both sculpture and drawing. In 1992 she summarized further research, including two chapters of particular interest to art therapists: "Color, Affect, & Expression" and "Art, Personality, & Diagnostics." Though critical of poorly designed studies and skeptical about finding group differences, Golomb is a believer in the overall diagnostic and therapeutic potential of art. Her recent work (Golomb, 2002) is an attempt to put children's art in a cultural context.

Some of the best investigations using naturalistic observation of creative behavior came from an interdisciplinary series of studies done at Harvard called *Project Zero*, which began in 1967 (www.pz.harvard.edu/index.cfm). That project was the basis for Howard Gardner's work (1980, 1982), and for Ellen Winner's (1982) book on the psychology of the arts—which included chapters on drawing development, brain damage, and mental illness.

There is also a fine chapter by Wolf in Gardner's 1982 book about stylistic differences among preschoolers, which is reminiscent of what Viktor Lowenfeld (1952, 1957) discovered about perceptual styles (visual and haptic) in his work with blind and partially sighted youngsters. The presence of such normal stylistic differences, and of intra-individual variability (Rubin, 2005b), make the diagnostic use of any single artwork or group of products exceedingly complicated. There are also a great many uncontrollable variables, like culture or hairstyle, making most diagnostic generalizations about art extremely uncertain.

Other observers of normal art activity and products included Rhoda Kellogg (1959, 1969), who found patterns in her large collection of art by normal preschoolers. *Understanding Children's Play* (Hartley, Frank, & Goldenson, 1952) described not only normal behavior, but also the therapeutic benefits of clay, graphic materials, and finger paints. One of the authors was Lawrence Frank, who had written the first book called *Projective Methods* (Frank, 1948).

Art therapists working with children were greatly influenced by such careful observational studies, including the classic investigation by Alschuler and Hattwick (1947/1969) of the relationship between *Painting & Personality* in normal preschool youngsters. The psychologist who invited me to do art therapy with schizophrenic children in 1963, Dr. Margaret McFarland, was one of the teachers participating in that study, no doubt contributing to her interest.

The hope of finding useful information in children's artwork was high during this period, resulting in rating scales for spontaneous drawings and paintings, like those developed by child psychologists Paula Elkisch[5] and Trude Schmidl-Waehner.[6] Peter Napoli's[7] diagnostic

use of finger painting, inspired by the work of Ruth Shaw (1938), was later used and amplified by others, like my college psychology professor Thelma Alper, whose excitement about a study relating finger paintings to socioeconomic level was contagious. Similarly, the *Easel Age Scale* was designed by psychologist Beatrice Lantz (1955) to study the growth and adjustment of normal young children through their spontaneous paintings.

Other well-designed investigations by developmental psychologists of relevance to art therapists were done by Cox (1992, 1997), Gardner (1980), Goodnow (1977), and Thomas and Silk (1990). Some of the research they report seems to validate at least some common projective hypotheses, like the symbolic significance of size or color. Their skeptical observations on the diagnostic use of art, however, are useful reminders of the nebulous state of this field of study.

While correlations between artwork and personality remain doubtful, drawing assessment of development levels has been shown to have somewhat greater validity. In 1963, Dale Harris revised and extended Goodenough's Draw-a-Man Test as a measure of "intellectual maturity" in children. In 1968, Elizabeth Koppitz refined procedures for the use of *Human Figure Drawings* (HFDs) by elementary school children to measure developmental level, as well as to assess adjustment via "emotional indicators" (cf. also Koppitz, 1984).

Art Therapists as Diagnosticians

Art Therapists and Projective Drawings

When art therapists seeing children were informally surveyed by the American Art Therapy Association (AATA) in 1991, it was found that they were almost as familiar with the DAP, H-T-P, and KFD as they were with the art therapy techniques on the list. Indeed, because of waning interest in projective drawings, Klepsch and Logie (1982) concluded "that people other than psychologists, professionals who work with children, should be prepared to acquaint themselves with what drawings have to say." It would appear that many art therapists have done just that.

Cay Drachnik's 1995 manual on the interpretation of children's drawings includes descriptions of the most common projective drawing tests, along with many traditional assumptions of the meaning of various aspects of both form and content. Stephanie Brooke's 2004 revision of her 1996 *Guide to Art Therapy Assessment* reflects art therapists' continued interest in the drawing tasks developed by clinical psychologists (6 chapters), while including more procedures devised by art therapists (10) than the first edition.

Like many art therapists, I have sometimes suggested themes used in projective drawing tasks for the simple reason that they are central to understanding individuals' perceptions of self and others—like the "Person" and "Self-Portrait" done by Jimmy in the following vignette. I was supervising a student who wanted to do an informal research study in the setting where I had just started an art program. Comparing self and person drawings seemed like a good and potentially revealing set of tasks, given the subjects.

Draw-a-Person and Self-Portrait in Assessment: JIMMY (5)

Jimmy was a five-year-old boy who was a residential student at the Home for Crippled Children in 1967 **(DVD 6.7)**. He was first asked to "draw a person," and proceeded to produce a picture of a clown **(A)**. This drawing was in fact rather advanced for his chronological age level, apparent immediately **(Figure 6.6)** without needing to score it on the Goodenough-Harris Scale (Harris, 1963).

He was then asked to make a self-portrait, and on the other side of the same paper he drew a human figure typical not of a five-year-old, but rather of a two- or three-year-old at a

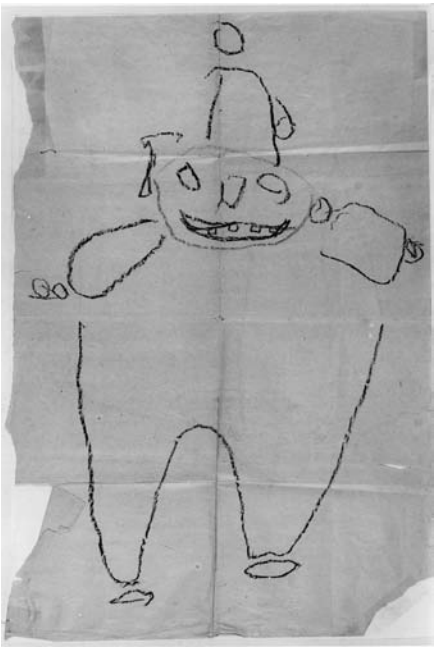

Figure 6.6 "Person" by Jimmy.

pre-figurative stage of development—a crude enclosure with rough indications of limbs and features **(B)**. When asked about his picture of himself **(Figure 6.7)**, Jimmy explained: "The legs got lost in the grass." It was a poignant statement of how damaged he felt, for Jimmy's legs were indeed lifeless: he was able to move only in a wheelchair.

His picture of the clown, on the other hand, showed how bright he was, since it was a superior human figure drawing for a child his age. The massive difference in the developmental level of his self-portrait indicated not only Jimmy's "body image" (Schilder, 1950), but also his rage and helplessness about his disorganized physical state. The self-drawing is particularly poignant in contrast to his choice of a clown, who can not only walk, but who can also jump and hop—and perhaps even "fly" on a trapeze.

Rating Scales by Art Therapists

Before describing how art therapists conduct assessments using creative media, we will note some of the work done by art therapist researchers in the development of rating scales for both artwork and art behaviors.

Rating Scales for Art Products

Art therapists working in research settings often collaborate with other professionals in developing more sensitive rating scales for spontaneous and directed art. The most extensive early studies were done by Hanna Kwiatkowska (1978) and Harriet Wadeson (1980) at NIMH, where they were able to construct imaginative tasks to study patient art. With the help of colleagues in psychiatry and psychology, they also developed scoring methods and rating manuals, the most elaborate one being the *Dent-Kwiatkowska Rating Manual*.

Figure 6.7 "Self-Portrait" by Jimmy.

Inspired by her studies with Kwiatkowska, Linda Gantt **(Figure 6.8)** has developed and refined the *Formal Elements Art Therapy Scale (FEATS)* (Gantt & Tabone, 1998), designed to measure variables in patients' drawings of A *Person Picking an Apple from a Tree (PPAT)* **(DVD 6.4E)** (cf. V. Lowenfeld, 1957). A similar effort has been under way since 1988 to rate drawings elicited in the *Diagnostic Drawing Series* developed and administered on the **DVD (6.14)** by Barry Cohen[8] **(Figure 6.9)**.

In both instances, the art therapist researchers have invited participation by colleagues in the collection and analysis of data, as has Rawley Silver, who has developed and refined rating scales for her drawing tests over a 30-year period (Silver, 1978, 2002, 2007).

Rating Scales for Art Behaviors

While not as common as drawing assessments, rating scales for art behaviors represent one of the ways in which art therapists attempt to assess the effectiveness of their interventions. Such approaches began in the 1960s, when behavioral objectives were introduced in education, and continue to be important, since accountability and evidence-based practices have become necessary for reimbursement and funding in many settings.

Behavioral assessments now characterize most evaluations in education, mental health, and rehabilitation and are used by art therapists to assess patient progress in a variety of settings, although there is no standardized format (Frostig & Essex, 1998).

For her doctoral research, Troeger created an art skills assessment for special education students, using a developmental scale to rate behaviors while working with art materials—drawing, painting, cutting paper, and using clay (Wadeson, 1992). When Fugaro (1985) adapted the *Silver Drawing Test* (Silver, 1978) for assessment with neurologically and emotionally impaired children, he included many behavioral measures as well as the drawing scales of the original instrument.

Figure 6.8 Linda Gantt, PPAT & FEATS.

Figure 6.9 Barry Cohen, DDS.

Figure 6.10 Pre-program art interview with blind child.

The following vignette from the 1970s illustrates such an approach. In order to assess change in a group of blind children with multiple disabilities, I designed a scale that rated behaviors and attitudes during the artistic process, and in relation to others.

Assessing Change After Seven Weeks of Group Art Therapy

In an exploratory art program with thirteen multiply-disabled youngsters at the Western Pennsylvania School for Blind Children in 1970, the children were first interviewed individually in order to be able to group them most effectively. Because of their disability, they were offered a wide range of sensory stimuli, as well as a choice of art materials **(Figure 6.10).**

Two observers using a 24-item, 9-point rating scale were asked to note where each child was on each behavioral dimension. Some items were descriptive of overall behavior, such as passive/active, tense/relaxed, distractible/involved, and depressed/alert. Others referred to the children's interaction with the therapist, like dependent/independent, suspicious/trusting, and withdrawn/outgoing.

Some items related to their use of the art materials, such as awkward/coordinated, impulsive/deliberate, stereotyped/original, or to their attitude toward their work, like critical/pleased. Yet others were about the nature of their creative process, for example, barren/fluent, rigid/flexible. An average of the two observers' ratings on each dimension was used. They agreed almost 90 percent of the time. In other words, the scale had high *inter-rater reliability.*

After seven weeks of group art sessions, we repeated the individual interviews with each child, again using the mean of two observers' ratings on each dimension **(Figure 6.11)**. The differences between the pre- and post-program scores were all in the desired direction. They were *statistically significant (beyond chance expectation)* on the following five dimensions: relaxation, involvement, independence, originality, and flexibility. These objective assessments confirmed our subjective sense of individual and group gains. Jimmy, for example, who had been so shy and lacking in self-confidence that at first he declined art altogether, had become comfortable with drawing, and more important, proud of his work **(Figure 6.12)**.

Figure 6.11 Post-program interview with partially sighted child.

Figure 6.12 Jimmy's pride in his drawings.

On the **DVD (6.8)**, you can see still photographs as well as excerpts from two of the post-program evaluation sessions, which were filmed because by then we had received a grant to record the program. There is no question that the growth indicated by the observers' ratings was evident to me and, I think, to the children as well, who were quite pleased with themselves. Because they had multiple disabilities, they had not been in any sort of art program at the school and were delighted with their accomplishments.

Art Therapy Assessments

Overview

Linda Gantt's chapter in *A Guide to Conducting Art Therapy Research* (Wadeson, 1992) was an excellent "description and history of art therapy assessment" 15 years ago. The next two chapters described a number of drawing batteries and art-based assessment procedures and instruments, including some unpublished materials.

Stephanie Brooke's recent revision of her book (2004) on that topic includes not only more art therapy assessments, but also references to material on the Internet. In a book addressed to non–art therapists (Rubin, 2005a), I included two chapters on the use of art in assessment, because I believe that art therapists' greater knowledge and flexibility about possible materials, themes, and ways of working can enrich other professionals' use of drawings to get to know the people they see.

There is no standardized or commonly accepted approach to diagnostic art interviews, any more than there is a universally accepted way of doing art therapy. A great many different and varied approaches are used by art therapists today. In the responses to a 1991 survey of those who work with children, many different art assessment tasks and batteries were described, in addition to the nine that were listed.

It seemed that art therapists at all levels of experience had modified existing techniques and created new ones, rather than relying on published tools. Perhaps because of this inventiveness, art therapists have typically contributed their own ideas to the evaluation so critical to effective treatment.

Unstructured Approaches

Some approaches to art therapy assessment are unstructured, like my own free choice procedure, for which I have also described ways of "decoding symbolic messages" in art and behavior (Rubin, 2005b). Edith Kramer (2000) suggested a series of art activities—drawing, painting, and working with clay—the sequence of which can be varied, and outlined "observational considerations" (**DVD 6.9**; cf. also **DVD 3.11H**).

Neither of these interviews specifies subject matter. In Bruce Moon's (1992) chapter, "The Role of Assessment," he proposed a wide range of choices of media and topic. He also noted the importance of attending closely to the individual's mode of working with the art materials.

I was surprised when I came across my original proposal for an art evaluation, which was dated April 1969. Although I had first suggested that a free choice be followed by offering a different art medium (like Kramer) and, if time permitted, requesting a self or family portrait (like many assessment batteries), I ended up finding the open-ended approach to be the most fruitful (**DVD 6.10**).

The following vignettes illustrate its power. For Evelyn, free art expression was able to provide evidence not available elsewhere. For Melanie, she needed the help of a "scribble" drawing to be able to create an image, from which she and I were then able to learn a good deal.

Art Assessment Reveals Depth of Pathology: EVELYN (16)

Sometimes an art interview is a peculiarly sensitive instrument where other assessment tools are not. Evelyn, a painfully shy adolescent of sixteen, was thought by the referring psychiatrist to be "mildly inhibited" but not "grossly disturbed." He referred her for an art evaluation because it was so hard for her to talk to him.

Her first production in a diagnostic art evaluation, however, was a painting on the largest size of paper available (18" x 24") of a stark purple "Tree" **(A)**. Asked what sort of place it was, she said it was "nice" and that she would like to be there, right *next* to the tree. Evelyn then paused and said instead that she would *be the tree itself.*

Her next drawing was a bizarre figure named "Fred" **(B)**, who she described as "an eighteen-year-old girl." She said that "Fred" was called "crazy" by the kids, and talked to herself because it was better than talking to others.

Although the referring psychiatrist remarked that the girl's art looked "sicker" than anything else, it was her subsequent suicide attempt that validated the confusion and withdrawal evident in her art work and her verbal associations to the imagery.

She was able to be treated through adjunctive art therapy while hospitalized, which was especially helpful during a period when she became mute. Retrospectively, the glove on Fred's hand and the denial of the body in that drawing, as well as the vaginal "split" in the tree, were clues not only to the depth, but also to the nature of her pathology, which became more apparent in her therapy over time. In addition to art therapy, Evelyn was also able to benefit from dance/movement therapy while in the hospital.

A Scribble Drawing Helps a Sullen Adolescent: MELANIE (15)

Melanie, age fifteen, had been referred to the clinic because of her oppositional behavior. Her rebelliousness had already caused her aunt, who had cared for her since her mother's abandonment in early childhood, to kick her out of the house. She was living with her older brother, but did not feel happy or accepted in his home.

Like many adolescents, Melanie was reluctant to draw spontaneously, since she was "no good" at art. So I suggested that she make a "scribble" drawing, a technique used by art therapists to help people get started. She was able to "find" an image in her scribble, and to develop it (**C**).

At first she said it was an "Eagle," then she changed her mind. "I think it's a 'Hawk' or something." Melanie went on to say that she would like either to *be* the bird or to *take care* of it, eventually deciding that she would rather be a caretaker. She went on to explain that eagles were in danger of becoming extinct—through people's neglect—and that she would like to work for the preservation of the species.

Much to my surprise, Melanie was then able to connect these ideas about her drawing to her own strong and unmet dependency needs. The Eagle/Hawk expressed her loneliness, as well as her hunger for love, acceptance, and family. The sharp beak expressed her biting rage, which was directed at those who had abandoned and rejected her, which was also reflected in the explosive, sullen, angry quality of her speech.

On the **DVD** you can view excerpts from two individual art evaluations—one with a 10-year-old girl (**D**) and one with a 17-year-old boy (**E**), both seen as outpatients.

Structured Approaches: Themes

Other art assessments specify subject matter, like the drawing of a *bridge* suggested by Ron Hays.[9] Like the human figure or the family, such topics are not chosen at random, but

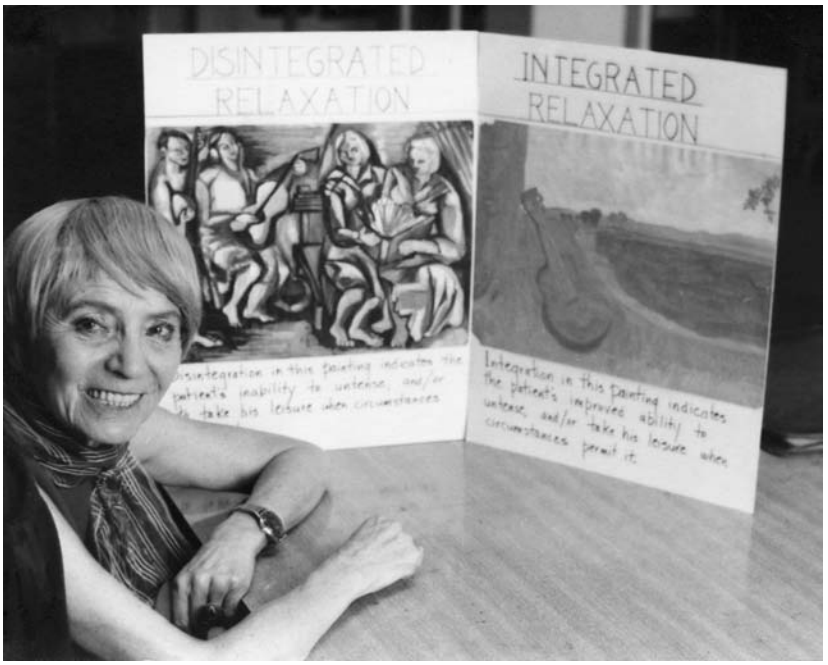
DISINTEGRATED
RELAXATION
INTEGRATED
RELAXATION
Integration in this painting indicates the patient's improved ability to unwind, and/or take his leisure when circumstances permit it.

Figure 6.13 Edith Zierer, creative analysis.

rather because they are assumed to tap significant symbolic issues. A bridge, for example, can represent connections and transitions. The added instructions to indicate the direction of travel by an *arrow*, and to show where the artist might be with a *dot*, further amplify the information.

Many projective themes have been proposed by art therapists, such as a rainbow (Shoemaker), a rosebush (Allan, 1988), or a road (Hanes, 1997)—each with a rationale. Noting that abused children often drew inclement weather, Trudy Manning[10] theorized that drawing *A Favorite Kind of Day* (*AFKD*) would reflect how a child viewed his interpersonal environment. She also designed and validated rating scales, using measures of weather, size, and movement.

Creative Analysis, the elaborate system developed by psychologist Ernest Zierer and his art therapist wife Edith **(Figure 6.13)**, was practiced at Hillside Hospital from 1943 to 1967. For assessment, they used "a battery of therapeutic painting tests which are structured but not explicitly directive of the patient's painting activity."[11] The sequence was flexible and determined by each individual's needs. The initial diagnosis was arrived at by making a record of specific elements in the artwork, and creating what they called a "psychogram." They devised a similarly visual way to represent progress over time, measuring the degree of *color integration* in a patient's artwork, and then recording their observations in what they called an "integration graph" **(DVD 6.11)**.

Art Assessment Batteries: Individuals

A battery—a series of tasks in a prescribed order—is the norm for diagnostic interviews in psychology. Hammer, the most vocal proponent of projective drawings, recommends a drawing battery. Indeed, most experienced clinicians agree that a single product—like a

single act or thought—cannot possibly be a valid sample for anyone being assessed, whether the focus is on their potential or their problems.

Thus, both structured and unstructured assessment batteries designed by art therapists usually encourage or specify multiple products. The first was proposed by Elinor Ulman in 1965 (Ulman & Dachinger, 1975), and is now known as the *Ulman Personality Assessment Procedure* (*UPAP*). The sequence of four chalk drawings on 18" x 24" paper is: (1) Free Drawing, (2) Draw Movements (following directed "drawing" in the air), (3) Rhythmic Scribble, and (4) Choice: Free or Scribble Drawing. On the **DVD (6.12)**, you can observe Elinor Ulman conducting a UPAP with two young adult inpatients **(A)** and two adolescent outpatients **(B)**. Her colleague, Gladys Agell, is shown conducting a UPAP with an adult **(C)**.

In 1988 art therapist Barry Cohen designed a three-picture tool, the *Diagnostic Drawing Series* (DDS). The pictures, done on 18" x 24" white drawing paper with 12 pastels, are: (1) Free Drawing, (2) Tree Drawing, and (3) Feeling Drawing (lines, shapes, colors). Modifications for children have also been developed. Many art therapists have contributed data to ongoing studies of the DDS, coordinated by Anne Mills. On the **DVD** you can see Barry Cohen working with one patient **(D)** and Anne **(E)** with another.

Mala Betensky, an art therapist also trained in clinical psychology, designed several different combinations of tasks as *art therapy diagnostics* for different age groups, which she described in her 1995 book with clear rationales for each: For ages 3–7: (l) Exploring Materials, (2) Free Drawing & Painting, (3) Clay, (4) Dollhouse Play & Story, (5) Family Drawing (crayons). For ages 7–10: (1) Free Media Experimentation, (2) Free Picture, (3) Scribble Drawing, (4) Family Picture, (5a) Work with Pipe Cleaners, (5b) Free Clay Modeling, (6) H-T-P (pencil & crayons), (7) 'Grouping Game.' For Pre-Adolescents, Adolescents & Adults: (l) Color-Form Blocks, (2) Poster Paints, (3) Free Picture, (4) Free Clay Sculpture, (5) H-T-P (pencil & crayons), (6) 'Self-in-the-World' Scribble, (7a) Adolescent Window Triptych, (7b) Family (realistic), (8) Family (abstract), (9) Colored Sociogram (You & Your Friends), (10) Free Picture.

Though Betensky incorporated projective drawing tasks, her modifications are those of an art therapist, like large paper for family drawings, or using color for a sociogram. She also designed original tasks, like the *Adolescent Window Triptych* (pictures of *Past, Present, and Future*).

While there is no videotaped record of Betensky administering any of these, on the **DVD (F)** you can see her doing part of an assessment of an adolescent who had returned to her for further individual art therapy. In asking Luis to identify objects using only tactile perception, it is likely that she was assessing his cognitive functioning.

Myra Levick's doctoral work on defense mechanisms in children's drawings (Levick, 1983) led to the development of the Levick Emotional & Cognitive Art Therapy Evaluation & Assessment or LECATA (Levick, 2001). The six tasks, done on 12" x 18" paper with 16 oil crayons are: (1) Free, (2) Self, (3) Scribble, (4) Developed Scribble, (5) Place, and (6) Family. The scoring is based on cognitive stages in graphic development, as well as emotional stages in the use of defense mechanisms. Craig Siegel, a colleague of Levick's, is shown on the **DVD (G)** working with a boy doing all of the tasks.

Art Assessments for Specific Purposes

Just as certain approaches might be especially appropriate for different age groups, so particular sets of tasks may be used for specific purposes or populations. In order to assess the *extent of stroke damage*, art therapist Drew Conger (1978, AATA Conference Proceedings) described using six tasks: (l) Build with Blocks, (2) Draw Around a Block, (3) Copy the

Shape Around a Block, (4) Draw a Clock, (5) Draw a House and a Tree, and (6) Match Colors (using chalk).

Patricia St. John described a similarly well-designed task battery for *children with neurological impairment,* which included copying, drawing from memory, a Human-Figure-in-Action Drawing (someone doing something), a Story-Sequence Drawing (draw a story with a beginning, a middle, and an end), and a Clay Human or Animal.[12] Both Conger and St. John had given serious thought to the individuals whose cognitive ability they wanted to assess, and had come up with tasks that would be both appealing and feasible.

With the emphasis on shortening hospital stays and using time efficiently, art therapists can contribute a good deal to triage (screening) for psychiatric emergencies. The pressure to gather diagnostic data as rapidly as possible has resulted in many creative ideas by art therapists, like Nancy Gerber's *Brief Art Therapy Screening Evaluation* or BATSE (1996). The patient is asked to draw "a picture of two people doing something in a place" in five minutes on small white paper using 8 fine-tip colored markers without using stick figures.

As in psychologist-designed projective drawing tasks, Gerber specifies the questions to ask and what to look for. Since it is so efficient and rich, it is now a routine part of the intake process at Friends Hospital. This has often happened with art therapy evaluations, even those that take more than the 30 minutes of the BATSE, because such a wealth of information can be gleaned in a very short time. The **DVD (H)** shows Gerber demonstrating the procedure with a volunteer graduate student.

Assessing Sexual Abuse Through Art

Art therapists have played an important role in trying to assess possible molestation, but are still looking for the answer to the question that pioneer Clara Jo Stember asked in 1977 (AATA *Conference Proceedings)* about art therapy and child abuse: "Are there graphic clues?" Many have looked for patterns in the drawings and paintings done by abused children (Brooke, 1997, 2007; Drachnik, 1995; Kaufman & Wohl, 1992; Malchiodi, 1997, 1998a, 2008; Murphy, 2001; Wohl & Kaufman, 1985).

Despite the wish to be able to protect children by finding reliable "graphic clues," whether by anecdotal observation or through experimental research, one art therapist concluded after twenty years of work with "child and adult survivors of sexual abuse" (including reviewing the literature in this area) that "At the present time, it has been consistently demonstrated that drawings alone cannot be used as evidence that sexual abuse has occurred" (Hagood, 2000, p. 246).

As for adults, Dee Spring (1993) collected her observations about graphic signs of sexual trauma in art by abused women in and described her *art therapy assessment* with rape victims: (l) This is Me, I Am, (2) My Space, (3) My Life's Road, and (4) My Family and Me. The topics would seem to be useful ones for any adult a therapist wants to get to know through art expression.

Assessing Spiritual Development Through Art

Ellen Horovitz (2002) created the *Belief Art Therapy Assessment* (BATA). Offered a choice of media and surfaces for drawing, painting, or sculpting, the person is asked: 1. "If you have a belief in God, draw, paint, or sculpt … what God means to you." 2. "If you believe there is an opposite force … draw, paint, or sculpt the meaning of that." Horovitz also suggested how to ask questions and what to observe in the person's attitude and artwork. The goal is not to assess cognitive or emotional states, but rather spiritual development or "stage of faith." On the **DVD (I)**, you can see Horovitz conducting part of such an assessment.

Art Assessment Batteries: Families

There are many possible variations in assessment batteries for families as well as in those for individuals, depending on the age and setting of those involved as well as the art therapist's preferences and style of working. In 1967 Hanna Kwiatkowska, inspired by the family therapy that was happening on her inpatient unit at NIMH, as well as by Elinor Ulman's UPAP series, designed the first *Family Art Evaluation* (Ulman & Dachinger, 1975; Kwiatkowska, 1978) **(DVD 6.13)**.

The idea had come to her serendipitously when visiting family members arrived during an individual art therapy session she was having with an adolescent, and she realized that important interpersonal information was revealed when they were invited to use art. For the evaluation, which was conducted with each family member standing at an easel, Kwiatkowska requested six tasks: (l) Free Picture, (2) Picture of Your Family, (3) Abstract Family Portrait, (4) Scribble Drawing, (5) Joint Family Scribble, and (6) Free. Tasks 2, 3, and 5 are demonstrated on the **DVD (A)** by Patti Rossiter and Mari Fleming.

In 1974 Rubin and Magnussen (Rubin, 2005a) adapted the idea to an outpatient clinic with younger children, using three tasks: (1) Scribble Drawings, (2) Family Portraits—abstract or realistic, choice of media and location, and (3) Family Mural. On the **DVD (B)** of our *Family Art Evaluation* you can observe the introduction of each task, as well as portions of the working and discussion time with one family.

In 1987, Helen Landgarten developed her *Family Art Diagnostic*: (1) Nonverbal Team Art Task (pairs of family members, each using one marker color on the same paper), (2) Nonverbal Family Art Task (whole family working on the same paper), and (3) Verbal Family Art Task (deciding and working together). The **DVD (C)** shows her working with a father and his daughter, requesting a task that requires that each make something individually and then put them together.

Parenthetically, a three-dimensional procedure was proposed in 1974 by Margaret Frings Keyes, the *Family Clay Sculpture*. No doubt there are many creative variations in this area.

Art Assessment Batteries: Couples

In 1971 Harriet Wadeson developed an *art evaluation battery for couples* as part of a research project at NIMH. She used four tasks: (l) Family Portrait, (2) Abstract Picture of the Marital Relationship, (3) Joint Scribble, and (4) Self-Portrait Given to Spouse—to "do anything you want to him or her." On the **DVD (D)** you can observe Wadeson inviting a volunteer couple to first create a picture together without talking **(1)**, then to draw self-portraits **(DVD 6.5)**, and after modifying each other's drawings, to discuss the changes **(2)**.

In 1984 the *Menninger Perspective* described Robert Ault's diagnostic drawing series for couples: (1) Free, (2) Family, (3) Joint Picture of Doing Something Together, (4) Individual Abstracts of the Marital Relationship, and (5) Self-Portrait Given to Spouse. Just as Kwiatkowska was inspired by Ulman, so did Ault borrow from Wadeson. There is much cross-fertilization in the still relatively small field of art therapy. In fact, a survey of assessment in art therapy with children commented on the apparent existence of "an oral tradition," in which techniques were passed on to students.

Selection/Creation Art Assessment Batteries

Silver Drawing Test of Cognition & Emotion

One of the most unusual approaches to assessment in art therapy grew out of research by Rawley Silver **(Figure 6.14)**. Inspired by her discovery in their art of untapped capacities in

Figure 6.14 Rawley Silver, Silver Drawing Test.

deaf children (Silver, 1978), she looked for ways to assess competencies through art. Silver used her own artistry to create the 50 pictorial *Stimulus Drawing Cards* that serve as stimuli for the *Silver Drawing Test* (Silver, 2001).

There are three tasks: (l) Draw from Imagination, (2) Draw from Observation, and (3) Predictive Drawing. The first involves selecting two images from the cards and combining them in a drawing that tells a story. In the years since the test was first developed, it has been continually revised, and it has been used with a wide range of people, including elderly stroke patients and at-risk adolescents (Silver, 2002, 2007). The three-task battery is now called the *Silver Drawing Test of Cognition & Emotion* (SDT) (Silver, 2002, 2007).

Although the test was originally designed to measure "cognitive and creative skills," like the psychologists who saw more in person drawings than IQ scores, Silver soon realized that feelings were being expressed too. She therefore published the *Draw-A-Story* test, using the first task of the battery, to screen "for depression and emotional needs."

Indeed, for many years the art therapists of the Miami-Dade public schools have been using her instrument as a screening device and to assess the effectiveness of their work (Silver, 2005). On the **DVD (6.14)**, you can observe Ellen Horovitz conducting the SDT with a deaf adolescent **(A)** and Peg Dunn-Snow conducting one with a young boy **(B)**.

Magazine Photo Collage

The Magazine Photo Collage was elaborated by Helen Landgarten in a 1993 book. Pointing out that the technique is relatively unthreatening and accessible to people of any ethnic background, she outlined an assessment protocol. Given a box of People Pictures and one of Miscellaneous Items, the client is asked to: (l) Select pictures that catch your attention, paste them on paper, and write or tell what comes to mind. (2) Pick out 4–6 pictures of people, paste on another paper, and write or tell what you imagine each person is THINKING and what he/she is SAYING, (3) Pick out 4–6 pictures that stand for something GOOD and something BAD, paste down and tell what they mean. (4) Pick out ONE picture from the People Box, paste down, and write or tell what is HAPPENING to that person. Ask "Do you

think the situation will CHANGE?" IF THE ANSWER IS YES, then ask the client to find a picture illustrating the change or tell WHAT will make it change.

The rationale for the series as well as for each task is clearly delineated. One advantage of the approach is that people of all cultures can easily find photographic images with which they can identify.

Face Stimulus Assessment

As part of her doctoral dissertation,[13] Donna Betts developed a projective drawing assessment that was initially designed for multicultural and disabled youngsters. The task ultimately involves selection, completion, and creation of a face using crayons on 8.5" x 11" paper aspect of the task. Like most art therapist–designed assessments, it is highly inventive, but, as Betts notes, it is not yet tested for reliability and validity (www.art-therapy.us/FSA.htm).

Finally, a fairly comprehensive review of evaluation in and through each of the creative arts therapies was published by Feder and Feder in 1998. It covers many areas, including projective techniques and art therapist assessments.

Concluding Thoughts

By now it should be clear to the reader that many varied approaches to understanding human beings through their art are alive and well in art therapy of the 21st century. While art therapists continue to probe and to work to refine their "third eye" (Kramer, 2000) in becoming even more sensitized to graphic language, they are also striving to be more objective. There has been a consistent attempt over time to be more systematic in the presentation of tasks as well as in the evaluation of data.

Although art therapists are sometimes the only clinicians with whom a regressed patient can "speak," the language of color and form is, like poetry, very difficult to quantify. And even if that can be accomplished, the whole is still greater, deeper, and much more meaningful than the sum of its graphic parts. Messages contained in artwork are received in the context of all associated behavior—before, during, after, and in response to images.

Despite the popular myth that art therapists can "see through" people by looking at their creations, the majority view the artist as the most knowledgeable expert about his or her own symbols. Most art therapists question formulaic approaches to understanding, and resist the temptation to be clever interpreters. They see patients as complex human beings, and many have trouble with the kind of labeling involved in psychiatric diagnosis. Nevertheless, art therapists are often called upon to assist in such tasks, and do have some unique tools.

Any time an art therapist can tell something from artwork that is not available in other ways it is potentially useful. For example, Rawley Silver (1978) saw a gifted artist in a deaf boy called Charlie. Edith Kramer (1958) found artistic talent in a delinquent named Angel (Ulman & Levy, 1981). I discovered that a deaf-mute named Claire was not profoundly retarded (Rubin, 2005b). Similarly, the DDS, a popular art therapy drawing battery, is said to help in predicting treatment course—like identifying the prefusion of "alters" in dissociative identity disorder (Kluft, 1993).

As part of the process of developing the certification examination, the Art Therapy Credentials Board (ATCB) surveyed registered art therapists. While agreement about most areas was impressive, there was so little consensus about assessment that a separate commentary was published in the AATA Journal:

> Although the general public often views art therapy as dealing with the use of drawings in a diagnostic manner … within the field of art therapy little consensus has

> developed over the years as to what types of assessments are legitimate and which ones (if any) should be taught to students of art therapy. There was much disagreement and ambiguity in the findings of the Art Therapy Practice Analysis Survey regarding this area.[14]

There is no question that the use of art for the purpose of assessment and diagnosis is extremely complex, which is reflected in the title of a panel of experienced art therapists at the 1995 conference—"Art-Based Diagnosis: Fact or Fantasy?"—a discussion published in the *American Journal of Art Therapy* (1996, p. 9). Despite the discomfort of art therapists with simplistic approaches to the topic, current trends in mental health and special education require that serious attention be paid to this area.

The assessment of individuals and families through art can contribute a great deal to such diverse areas as: differential diagnosis, clarifying family dynamics, the evaluation of medication effects, or the prediction of dangerous behavior. Moreover, art can enable people to reveal both hidden conflicts and *potential capacities.* Assessing strengths is at least as vital to helping someone as assessing weaknesses.

Art is very rapid and extremely rich, both of which are relevant in times of shrinking resources. A sophisticated art therapist is aware of the hazards as well as the potential in understanding others through their creative work. Used with respect as well as restraint, art can be a powerful tool in diagnosis and assessment. As David Henley wrote:

> We attempt to confirm, moderate and predict the outcome of our treatment process through the fervent study of client artwork. Yet we must do so cautiously and in reverence to the artwork, which tells us so much more than we can describe.[15]

I couldn't agree with him more.

Endnotes

1. From Projective Methods for the Study of Personality," by L. K. Frank, 1939, *Journal of Psychology, 8*, 389–413.
2. "Drawings by Children as Aids in Personality Studies," by K. E. Appel, 1931, *American Journal of Orthopsychiatry, 1,* 129–144.
3. "The H-T-P Technique, a Qualitative and Quantitative Scoring Manual," by J. N. Buck, 1948, *Journal of Clinical Psychology, 4,* 317–396.
4. "A Clinical Note: The Kinetic School Drawing, by H. T. Prout & P. D. Phillips, 1974, *Psychology in the Schools, 11*, 303–306.
5. "Children's Drawings in a Projective Technique," by P. Elkisch, 1945, *Psychological Monographs*, *58*(1); "The 'Scribbling Game'—a Projective Method," by P. Elkisch, 1948, *Nervous Child*, *7*, 247–256.
6. "Formal Criteria for the Analysis of Children's Drawings and Paintings," by T. R. Schmidl-Waehner, 1942, *American Journal of Orthopsychiatry*, *17*, 95–104; "Interpretation of Spontaneous Drawings and Paintings," by T. R. Schmidl-Waehner, 1946, *Genetic Psychology Monographs*, *33*, 3–70.
7. "Finger Painting," by P. J. Napoli, 1951, in *An Introduction to Projective Techniques*, edited by H. H. and G. L. Anderson, Englewood Cliffs, New Jersey: Prentice-Hall, pp. 386–415.
8. "The Diagnostic Drawing Series," by B. M. Cohen, J. S. Hammer, & S. Singer, 1988, *The Arts in Psychotherapy, 15*(1), 11–21; "An Introduction to the Diagnostic Drawing Series: A Standardized Tool for Diagnostic and Clinical Use," by B. M. Cohen, A. Mills, & A. K. Kijak, 1994, *Art Therapy, 11*(2), 105–110.

9. "The Bridge Drawing: A Projective Technique for Assessment in Art Therapy," by R. Hays and S. J. Lyons, 1981, *The Arts in Psychotherapy, 8,* 207–217.
10. "Aggression Depicted in Abused Children's Drawings," by T. M. Manning, 1987, *The Arts in Psychotherapy, 14,* 15–24.
11. "Creative Analysis," by E. Zierer, 1987, *Art Therapy,* 114.
12. "Assessment Battery for Children with Neurological Impairment," by P. St. John, 1992, *Art Therapy*, 67.
13. "Developing a Projective Drawing Test: Experiences with the Face Stimulus Assessment (FSA)," by D. J. Betts, 2003, *Art Therapy: Journal of the American Art Therapy Association*, *20*(2), 77–82.
14. *Art Therapy*, 1994, p. 151.
15. Henley, D. (1997). *Art Therapy,* p. 57.

CHAPTER 7

Technique(s)

The only technique of art therapy is the technique of relating to a patient through art.

Hanna Kwiatkowska

We experience it [a dream] predominantly in visual images; feelings may be present too, and thoughts interwoven in it as well; the other senses may also experience something, but nonetheless it is predominantly a question of images. Part of the difficulty of giving an account of dreams is due to our having to translate these images into words. "I could draw it," a dreamer often says to us, "but I don't know how to say it."

Sigmund Freud, quoted by Margaret Naumburg

Introduction

As Margaret Naumburg often pointed out, "Although Freud made the modern world aware that the unconscious speaks in images, he did not follow the suggestion of his patients that they be permitted to draw their dreams rather than to tell them. Art therapy, however, encourages just such an expression of inner experience" (1966, p. 2). This was the basis for Naumburg's conception of *Dynamic Art Therapy*; that is, promoting the release of spontaneous imagery. But it is not the only way to proceed.

In fact, one of the most pleasurable aspects of art therapy is the creative challenge of deciding what to do and how to do it. As you have seen, there are many different ways of using art to achieve some kind of understanding in assessment. Similarly, there are many different ways of using art as a therapeutic modality. The specific approach chosen depends upon the *goals* of the particular intervention, the context in which it occurs, and the range of what is possible. Art is used *in, as*, and *for* therapy in a variety of ways.

Regardless of what is done, there is a series of necessary steps noted earlier. They begin with setting the stage, a major element in promoting expression in art therapy. A well-prepared environment can inspire creativity, whereas a confusing or uncomfortable one can have a most inhibiting effect. Introducing the task, whether free or specified, is also critical, since instructions need to be both clear and inviting. This is all part of the art therapist's

special area of expertise, evoking expression. Another element central to art therapy is facilitating that expression once it has begun, which requires sensitivity as well as skill.

After the work is completed, the art therapist turns her energies to helping the artist to learn from expression—from the process of creating and from the art product that is made. At each step of the process, art therapists use what they know about art and therapy to make the experience as helpful as possible for the person(s) involved.

This work, like all therapy, is most effective when it is done *artistically*, with tact, sensitivity, and a well-integrated *technique*. Although I added the optional "s" to this chapter title, I have been concerned, as was Hanna Kwiatkowska quoted above, about the apparently insatiable hunger among beginners for lists of *techniques*. I suspect Kwiatkowska would have agreed with dancer Rudolf Nureyev, who said "the reason for technique is to have something to fall back on when you lose your inspiration." Despite those insecure practitioners who want to be told what to do, most art therapists value individual creativity, including their own.

Evolution of Art Therapy Technique

Because of its historic roots in psychoanalysis, free art, like free association, was initially the most common method in art therapy. Although some of us still feel most comfortable with that approach, there is much to be said for a thoughtful consideration and selection of specific tasks, especially under circumstances such as time-limited therapy or work with certain groups.

Ernest Harms long ago called for art therapists to "design specific art interventions to address specific psychopathology."[1] Aina Nucho's (2003) book, which has been thoroughly revised since the first edition of this book, contains a thoughtful discussion about what an art therapist might do during each phase of the therapeutic process. The names she coined are useful too: *Unfreezing, Doing, Dialoguing, Ending*, and *Integrating*. Dr. Nucho articulated many of the considerations that go into decisions about what to offer, how to offer it, and how to behave during each phase of a session and of a course of art therapy. This chapter will offer just a sampling of the many ways art therapists work.

Evoking Expression (DVD 7.1)

Warming Up

Aina Nucho gave considerable attention to the idea of what she called *Unfreezing*. Overcoming natural resistances and blocks to creativity is often called *Warming Up*. All art therapists are concerned with helping individuals of any age who are uneasy about using art media. From Florence Cane's (1951) use of rhythmic body movements before a scribble drawing, to the recent popularity of guided imagery, art therapists have always looked for methods of releasing the creative stream. For they are confident that such a force flows in all human beings, even though it may be temporarily dammed up and therefore inaccessible.

Several popular techniques for loosening inhibitions use some kind of *stimulus,* like music, stories, or fantasy. It may be active and focused, as in a planned sequence of activities, or it may be background and subliminal, as in the soft lighting and music provided by art therapist Bernard Stone to enhance the dreamy atmosphere of his hospital studio, a place I visited 20 years ago but have never forgotten. I have found that by modifying the light—by using candles, flashlights, or projectors and shadows—I can also promote an altered state of mind. On the **DVD (A),** you can see Janie Rhyne motivating an intellectual group of adults

by suggesting body movements and sound making, as well as translating their impulses onto the paper with crayons.

Pictorial Stimuli

Stimulus drawings **(B)** were originally created by art therapist Rawley Silver for assessment. Although her initial purpose was diagnostic, she and others have reported that the set of 50 line drawings can be helpful in art therapy with people who have cognitive impairment, such as chronic schizophrenics or stroke patients (Silver, 2001). They are also useful in overcoming resistances, as with suspicious adolescents. First, the pictures—of people, animals, places, and things—are presented. Next, the person chooses some, imagines something happening, and shows it in a drawing.

Another easily available and frequently used source of visual stimulation are *photographs,* which can become all or part of the final product, as in Helen Landgarten's *Magazine Photo Collage*. On the **DVD (C)**, you can see Landgarten's colleagues, Shirley Riley **(1)** and Maxine Junge **(2)**, using photographs to help families to create.

Many art therapists have also used *art reproductions* in varying forms—from postcards that can be handled and sorted, to slides that are projected and magnified. On the **DVD (D)** you can see Trude Wertheim-Cahen, an art therapist from the Netherlands, describing her way of using reproductions with her clients.

Visual Starters

These are especially popular with art therapists of all persuasions, since they act as a stimulus for the person's own creative ideas. Both Prinzhorn (1922) and Cane (1951) referred to the Renaissance painter, Leonardo da Vinci. His sources of inspiration were ambiguous visual forms, such as the variegated colors and cracks on stones and walls, or on wet, crumpled-up paper. The *scribble,* used interactively by Winnicott (1964–68, 1971b) and after body movement by Cane (1951), is a similar ambiguous stimulus. In fact, it is probably the most widely used *visual prompt* in art therapy, and there are many variations on the theme.

Aina Nucho (2003) described several examples of what she called the *Free Flow Technique*. Art therapist Evelyn Virshup (1978) invited her patients to drag a kite string soaked in ink across the paper, then to develop the abstraction into an image. On the **DVD (E)**, she is doing that with a group of patients in a drug rehabilitation program.

I often suggest "fooling around" with paints on wet paper as a way of getting ideas for pictures. Brown (1967) "drew out" schizophrenic patients by placing a *dot* on the paper, Hays used a *dot-to-dot* exercise with children too young to use a scribble as a way of developing an image, and Vick suggested *Prestructured Elements*[2] for teenagers.

Using the Nondominant Hemisphere

There are other kinds of loosening up or unfreezing techniques, which are thought to depend on accessing the nondominant hemisphere of the brain. One involves drawing with the opposite of the preferred hand. On the **DVD (F)**, expressive arts therapist Natalie Rogers suggests that to Robin, who she is seeing for the first time. Another requires copying a picture viewed upside down (Edwards, 1979).

Rapidly executed *gesture drawings* were first suggested by Kimon Nicolaides (1941) in *The Natural Way to Draw*. Another of his ideas, *contour drawing*, was instrumental in curing Elizabeth "Grandma" Layton's lifelong depression (Lambert, 1995; Nichols & Garrett, 1995).

Art therapist Robert Ault (1986), who brought Layton's story to the professional community, reported that doing regular contour drawing seems to have an antidepressant effect. He

tried the method on himself, students, and patients, to surprisingly good effect. He hypothesized that there was a neurological effect that was salutary (Ault, 1996). On the **DVD (G)**, you will see Layton's story **(1)**, as well as a therapy group where Ault used contour drawing **(2)** and the book he wrote about it **(3)**.

Stimulating Materials and Methods

Using the element of speed, psychiatrist Wilhelm Luthe (1976) suggested a structured approach based on what he called "autogenics." His *Creativity Mobilization Technique* consisted of producing a series of 15 painting exercises in a 30-minute period—four times a week for six weeks.

Sometimes stimulating media are used deliberately, as in the treatment of Gloria, a young widow in her twenties who came for weekly art therapy.

Regressive Media Help in Dealing with Shame: GLORIA (29)

Gloria had vocally expressed her disgust at the finger paints, always noticing but never using them. I had asked if she could describe her feeling of revulsion, but she found it hard to define. I then wondered if we might not find out more if she were to try the paints, despite her negative response. She was willing to do so in an openly experimental way; and it was quite a powerful session, referred to many times in succeeding months.

She began by feeling and expressing disgust, but gradually got more and more into it, exclaiming with glee, "Ooh! What a pretty mess!" After a tentative beginning, she took large gobs of paint, and eventually used both hands and fingers with a high degree of freedom **DVD (H)**. Her unexpected discovery was that she liked it, that it was not unpleasant as she had anticipated, but that it was actually fun. She related this surprise to her initial anxiety about getting her daughter out of school for morning appointments, and her discovery that it was neither uncomfortable nor harmful as she had feared.

Her associations to the first painting **(1)** were that it was a series of "Roads" that led to various places, and that she had to decide where she was going, a fairly accurate description of where she was in her life at that time. The second she described as "like Hell, a Storm with Lightning and Turmoil," **(2)** and ended up talking about her own feelings of sinfulness and guilt over sleeping with a man to whom she was not married. The shame she felt about being "dirty" was stimulated by the medium itself, as well as by the images she projected onto her finger paintings, which were nonrepresentational.

Mental Imagery

The evocation of visual imagery has been used by many clinicians, beginning with Freud, to stimulate memory, fantasy, and awareness of feelings. It has also been used to facilitate art activity. I became interested in spontaneous mental imagery during my psychoanalytic training, and began reading the rapidly mushrooming literature on the topic.

As with studies of drawing development, imagery was long dormant in psychology, largely because it is so introspective and hard to quantify. Due to its frequent use in behavior therapy techniques like desensitization, however, during the last quarter of the 20th century the study of mental imagery once again became a lively arena (Watkins, 1984). This interest is reflected in the existence of the International Imagery Association (*Journal of Mental Imagery*) and the American Association for the Study of Mental Imagery (*Imagination, Cognition, & Personality*). Clinicians who use mental imagery in therapy sometimes invite people to draw what they have seen in the mind's eye, like psychiatrist Mardi Horowitz (1983).

Figure 7.1 James Consoli, *Psychimagery.*

Working at the Menninger Foundation, Don Jones developed an assessment (the *Don Jones Assessment*), which combined guided imagery with drawing. The patients, in a relaxed state, are invited to imagine a journey, stopping at four key points. At each point, they are asked how they would proceed, and are told that they will be drawing a picture of their answer. Each situation is carefully designed to represent a different kind of universally stressful problem. They are then asked to draw a picture of what they imagined. Both exercises are followed by a series of structured questions. Like Jones, most clinicians using mental imagery along with art request drawing or painting an image after it has been "seen." Jones and his colleagues, who studied the protocol, found it to be as useful in treatment as in assessment.[3]

Art therapist Vija Lusebrink (1990) discussed the relationship between art therapy and mental imagery, and Aina Nucho (1995) devoted an entire book to the topic of mental imagery. Art therapist James Consoli **(Figure 7.1)** used a combination of hypnosis and mental and graphic imagery to help a survivor of childhood sexual abuse recover and work through her traumatic memories. On the **DVD (I)**, you can see excerpts from the videotape he made about his approach, which he called *psychimagery* (Consoli, 1991).

A Series of Images

Making a series of images is another evocative technique, one used by art therapists in a variety of ways. Bernard Stone, who worked with hospitalized adults, reported on a *sequential graphic Gestalt,* where the client was asked to rapidly draw a series of pictures in response to his own painting (Jakab, 1975). Psychiatrist Mardi Horowitz (1983) invited patients to do a series of six drawings, beginning each time by staring at a dot in the middle of the page until they saw an image. On the **DVD**, art therapist Trude Wertheim-Cahen **(D)** demonstrates how a series of drawings beginning with a scribble helped one of her patients.

Stimulated by my analytic training, I experimented with a similar idea using various media, which I called *free association in art imagery* (1981 AATA *Conference Proceedings*). On the **DVD (J)**, you can see some workshop participants doing this exercise, and then exploring together the ideas stimulated by the sequence of images each has created.

These approaches using art materials resemble free association in mental imagery, which in some ways is what happens in psychoanalysis, but which has also been requested at times by clinicians. They also resemble *Active Imagination* as practiced by Jungian analysts (Chodorow, 1997), who encourage not only mental imagery, but also art, movement, and drama as ways to enhance the associative process. On the **DVD (K)**, you can see Jungian expressive arts therapist Carolyn Grant Fay inviting her client to move in response to a drawing.

A *series of cartoon drawings* was proposed by Crowley and Mills, Ericksonian child therapists. Using children's natural fascination with cartoon characters, they suggested various exercises to parents and teachers as a way of helping children to deal creatively with stressful situations in their book, *Cartoon Magic* (1989).

Facilitating Expression (DVD 7.2)

Motivational Techniques

Although young children are less likely to be inhibited about using art materials than adolescents or adults, they may still have difficulty creating authentically. Edith Kramer has proposed a classification of *ways of using art materials* that is relevant for all age levels: (1) Precursory Activities, (2) Chaotic Discharge, (3) Art in the Service of Defense (stereotypes or copying), (4) Pictographs, and (5) Formed Expression.

Such an analysis is useful not only in understanding what is produced, but also in thinking of ways to motivate people to achieve a higher level of artistic expression. Stereotyped work, for example, is common during what Viktor Lowenfeld (1957) called the "schematic" stage in normal artistic development, for which he suggested various motivational techniques.

One of his central ideas was the importance of what he called the child's "self-identification" with whatever was being represented. Lowenfeld recommended that children not only *imagine* doing the activity to be drawn (like brushing teeth), but *enact* it as well, thus activating the child's sensory awareness. He also proposed the respectful notion of "extending the frame of reference"—working within and with the child's imagery, rather than trying to suppress even bizarre ideas.

Artistic Interventions

Another set of Lowenfeld techniques involved the use of the worker's "auxiliary ego" to assist the child when his own resources are not sufficient to function autonomously. That is one way to think about *closure,* which means starting a clay modeling or drawing for the child to finish. David Henley (1992, 2002) has used Lowenfeld's ideas in art therapy. He also noted that pictorial interventions—which Edith Kramer called "using the art therapist's *third hand*"—are compatible, as long as they do not distort. On the **DVD (A)**, you see Shirley Riley starting a drawing so that a patient with Alzheimer's disease, who had been unable to begin drawing, can finish it.

One clinician who used his own drawing and associative processes in order to relate to children was British psychoanalyst D.W. Winnicott, who took turns making and developing a series of pencil "squiggles" into pictures. Although playful, the technique penetrates deeply, and requires considerable expertise on the part of the therapist. It is particularly effective where time is of the essence, as it often was for Winnicott **(Figure 7.2)**, who might have only one consultation with a child brought to see him from a great distance (Winnicott, 1964–68, 1971b).

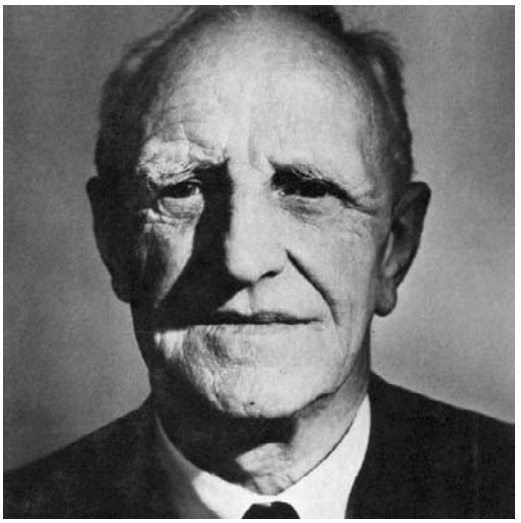

Figure 7.2 D. W. Winnicott, squiggle game.

Like any other activity by the therapist, doing art can be harmful as well as helpful to the patient. Frances Kaplan's *Drawing Together* is a thoughtful discussion of working along with a patient in art, noting those for whom it is beneficial, as well as those for whom it might be disruptive.[4]

Many art therapists have reported working along with a patient, group, or family (Kapitan, 2003; McNiff, 1981; B. Moon, 1995, 2006, 2007; C. Moon, 2002). My own concern is that the art therapist has sufficient self-awareness, so that what she creates does not impinge on the patient's creativity. On the **DVD (B)**, you can see Bruce Moon working alongside a student during their final supervision session.

Another use of the art therapist's artist-self is to *draw a portrait of a patient,* perhaps while he is creating. On the **DVD (C)**, both Vera Zilzer and Alice Karamanol are seen doing this in groups. With her schizophrenic patients in a partial program, Zilzer gives her portrait as a gift to the model **(1)**. With her adolescents in a special school, Karamanol does an outline and invites the student to complete it **(2)**. She comments in the excerpt that drawing someone's portrait is a very intimate kind of attention, "a way that I get to touch them without touching them."

Many of us have done this, as in my own experience of drawing and painting **(Figure 7.3)** Ellen, an elective mute, when she was acting especially hostile. This same girl also stimulated me to invite her to work together on a *joint nonverbal drawing.* Her story is told in Chapter 9. Other clinicians have reported doing this with withdrawn patients of all ages, like Mardi Horowitz (1983), who drew and painted with regressed schizophrenics. *Drawing dialogues* have also been used as a way of "breaking the ice" (Landgarten, 1981).

Many of us have also found ourselves drawing "on demand" with the patient giving instructions, like Irene Rosner did for Eddie, a quadriplegic who told her what and how to create. On the **DVD (D)**, you can see Irene doing this for him in the early part of his treatment **(1)**. Later, Eddie was able to hold a brush in his mouth and create his own drawings and paintings **(2)**.

Having developed a *Boss-Slave game* to deal with authority issues in work with mothers and children (Rubin, 2005a), I have found it useful at times to "follow orders" with patients

Figure 7.3 My painting of Ellen, an elective mute.

of all ages. One art therapist reported acting as *graphic secretary* for the child, and another used the similarly playful traditional *fold-over* drawing game (Wadeson et al., 1989).

Although the use of one's artist-self is probably quite common in the work of art therapists, there may be reticence in reporting it because of the obvious counter-transference hazards. It is indeed possible that an art therapist's own exhibitionism, competitiveness, or lack of sensitivity to the patient's defenses might cause such an experience to be disruptive. Another reason for the selective use of this tool is that it can absorb too much of the artist clinician's attention.

Nevertheless, most art therapists have worked with materials alongside patients in a variety of ways, and for a great many possible reasons. One is to model behavior, as in the "Pied Piper" effect I described in Chapter 4; another is to defuse anxiety about using materials and being observed, which I did in a family art evaluation that is seen on the **DVD (E)**. Yet another is to convey an idea graphically, a useful form of *interpretation*.

An original method of mutual communication has been described by art therapist Mildred Lachman Chapin (Rubin, 2001). After first talking with the patient about current concerns, both draw simultaneously, neither one seeing the other's image **(Figure 7.4)**.

Figure 7.4 Mildred Lachman Chapin drawing with a client.

After creating the drawings, both parties share their pictures and thoughts about each of them. In my opinion, this very powerful technique is appropriate—like Winnicott's—only for experienced practitioners. You can see Lachman-Chapin doing this with a patient on the **DVD (F)**.

An art therapist might use her artist-self either *simultaneously* or *in turn*. Her creation might be a reflection *of* or *to* the patient. The art therapist's ability to use visual language expands her clinical repertoire, just as art enlarges expressive possibilities for the individual(s) hoping to grow through treatment. As with any intervention, the injunction to do no harm applies; when the art therapist uses herself as artist it should be with thoughtfulness and care and an awareness of its impact on the patient—and, of course, in that person's interest.

Drawing Workbooks and Guides

Like fairy tales and art in therapy, the cartoon story drawings proposed by Crowley and Mills in *Cartoon Magic* (1989) offer both disguise and distance, enabling loaded themes to be dealt with more comfortably. The popularity of such *self-help materials*, for both adults and children, has not been lost on art therapists.

Some have developed *creative workbooks* **(G)** that suggest various drawing and writing activities. The pioneer in this area was Lucia Capacchione **(1)** (2001), whose *Creative Journal* **(2)** was the first of her many drawing workbooks (www.luciac.com).

Barry Cohen and his colleagues published a creative workbook for those suffering from posttraumatic stress disorder (Cohen, Barnes, & Rankin, 1995) **(3)**. Graves (1994) created one for those who have been bereaved **(4)**, and Nichols and Garrett (1995) wrote one for those who are depressed **(5)**.

Heegaard's series of 18 workbooks for children, some to be used with parents, and her guide for facilitators (Heegaard, 1996) deal with specific problems, like adoption, illness, death **(6)**, and self-control.

Figure 7.5 A child drawing in the hospital.

While working at a child guidance center, I tried out a variety of *drawing books* with children, including one on reality testing ("Make-Believe Drawing Book"), one on self-concept ("My Book About Me"), and a "Hospital Drawing Book" for children in a medical hospital **(Figure 7.5)**. My young subjects' responses were uniformly positive, confirming the need for such tools. In 2002 the American Psychological Association published one I designed for children whose parents are separated or divorced, *My Mom and Dad Don't Live Together Anymore* **(7)** (Rubin, 2002). I suppose it is meeting a need, since I was recently told that it had been translated into Italian and has sold well in Italy.

Closely related to drawing workbooks are books that encourage readers to explore their own creativity, some of which have been created by artists like Julia Cameron, whose *The Artist's Way* (2002) has a parallel workbook (Cameron, 2007). Janie Rhyne (1995), an art therapist who began her work in the human potential movement, devoted a large part of her book to helping readers gain access to their own creativity. On the **DVD (H)**, you can see Rhyne inviting members of a workshop group to get in touch with theirs by working with clay with their eyes closed, in order to stimulate both relaxation and imagery.

Art therapists have also contributed to this literature, and are now including more exercises in their own books, with directions to the reader for ways of implementing their suggestions (Allen, 1995, 2005; Fincher, 1991; Malchiodi, 1998, 2002; B. Moon, 2006).

Deciding What to Do and Why

There are a number of books by art therapists for those who want ideas about what to do, primarily with groups, though many can be used with individuals as well. Most cover a wide range of materials and processes and are organized according to such categories as goals, media, or themes (Buchalter, 2004; Campbell, 1993; Liebmann, 2004; Makin, 1999). Some are based on, and especially applicable to, particular settings, such as schools (Ross, 1997) or hospitals (Darley & Heath, 2008).

Being inventive, art therapists have come up with a great variety of intriguing and idiosyncratic ways of working. There is usually some kind of systematic deliberation behind

choice of media, degree of task structure, and the nature of the task itself. The goal was central in an early attempt to classify *Techniques for Individual and Group Art Therapy* (Ulman and Dachinger, 1975), whether for: exploration, rapport building, expression of inner feelings, self-perception, interpersonal relations, or the individual's place in the world (cf. Robbins, 1994).

Thinking clearly about the *goal* of an art activity makes it easier for the therapist to decide what to do. If it is *diagnostic,* to *assess* someone's perception of their family, requesting a family drawing would clearly be in order. If the wish is to see how someone sees himself, a self-portrait might be in order. If the goal is to ascertain a patient's ability to function independently, then a free choice procedure would make sense.

On the other hand, the goal might be primarily *therapeutic*, such as helping a constricted individual to become freer. In that case, activities like developing an image from a scribble, or closing eyes and reporting whatever imagery arises might make sense. If the goal is to increase self-esteem, an activity with a high potential for success would be in order, such as modeling with colored plasticine clay or creating a torn tissue-paper collage with thinned white glue and brush on white drawing paper, both of which result in attractive products. On the other hand, if the aim is to help a couple to become aware of their interaction patterns, working together without talking might be indicated. These are just a few examples of ways to use goal setting to decide what to do and how to do it.

In deciding how to proceed, art therapists have three main elements at their disposal, which can have varying degrees of structure or specificity: *media*, *theme,* and *manner of working*. Regarding media, people can be offered an open choice from among two or more alternatives (e.g., drawing or painting), the specified use of a class (e.g., drawing materials), or a request to use a specific material (e.g., pastels).

Knowing the characteristics of different materials helps art therapists greatly. To assess the degree of elaboration in someone's drawing, for example, it is necessary to offer only easily controllable media like drawing pens, colored pencils, or fine felt tip markers, which will allow them to represent details. On the other hand, if people need to cover a large area rapidly, a medium like thick poster chalks is more appropriate.

Art therapists Sandra Kagin Graves **(Figure 7.6)**, who conceptualized *media dimensions variables,* and Vija Lusebrink **(Figure 7.7)** (1990) together elaborated the *Expressive Therapies Continuum* (ETC) model. It postulates four levels of image formation and information processing, in a developmental sequence from *kinesthetic/sensory* (K/S) to *perceptual/aȧective* (P/A) to *cognitive/symbolic* (C/S). *The creative level* (CR) can be present at any and may be a synthesis of all. This model offers a way to think about media and activities according to specific objectives for people at different levels of functioning. Lusebrink gives a number of examples of how to use it in decision making. Lisa Hinz (2009) has recently elaborated this model in a new book on the ETC.

Another area where art therapists have options is the *theme,* which can be open-ended, such as "Do what you want," or more or less specific, as in "Draw a feeling" or "Represent anger." When in doubt, it is safest to stay at a more symbolic level, since art allows for a substantial degree of disguise. For example, if the goal is to help someone to become aware of anger at their mother without risking resistance, a request to draw a witch might be more fruitful than asking for a picture of the parent herself.

The third element art therapists have at their disposal in deciding what to do is the *manner* in which the task is to be accomplished. It can relate to the *interaction*, as in "Choose a partner and draw each other," the *time*, as in "Do a one-minute gesture drawing," or the *method*, as in "Model a piece of clay with your eyes closed." A central variable is the degree

Figure 7.6 Sandra Kagin Graves, media dimension variables.

Figure 7.7 Vija Lusebrink, Expressive Therapies Continuum.

of structure in the task itself, a topic that has yet to be systematically investigated, but about which art therapists have reported impressions.

Wadeson et al. (1989) described work with two retarded young people, who required different approaches because of their different levels of functioning. One therapist found that a nondirective approach with hospitalized depressed patients resulted in defensively cheerful images, whereas specific themes, like "Barrier Drawings," helped patients to express the pain and anguish they were actually feeling (Wadeson et al., 1989). Conversely, McNeilly (2006) reported that he had "abandoned the directive approach in favor of the non-directive" with an outpatient art therapy group.

The advantages and disadvantages of directive and non-directive approaches have yet to be evaluated in a systematic fashion. What seems evident is that the more non-directive approaches are more likely to be successful with high functioning clients, whereas the more impaired recipients of art therapists' services often seem to require more structured approaches. As Waller (1993) noted, even those favoring open approaches have needed to modify them for patients who function better with clear external structure, such as psychotics, individuals who are cognitively challenged, or children with attention deficit disorder (cf. Paraskevas, 1979).

What is evident in reviewing the literature is the creativity in the field. An experienced art therapist is familiar with a wide variety of media and processes. She also has in her armamentarium many different ways to offer materials, and tasks can range from unstructured to highly specific. The following vignette describes the thinking behind designing some tasks in family art therapy.

Specific Tasks Help a Family to "See" Problems

A psychologist and I worked as co-therapists with a family on a weekly basis for 32 sessions over the course of a year. We recommended this modality on the basis of their response to a family art evaluation; and the fact that the boy Tim's stuttering, which was virtually absent in the children's group he had attended at the clinic and at school, was still evident at home and a source of distress for the parents (Rubin, 2005a).

Most of the time, the family members were free to use whatever they wanted, and to make whatever they wished. Tim and his sister enjoyed using the art materials as did the parents who were bright and articulate. With two therapists in a large space, we were able to conduct some individual and couple therapy, as well as talking with the family as a whole in the sharing time at the end of each session. In addition to free choice, we also assigned certain topics based on our weekly post-session collaborations **(DVD 7.3)**.

The first topic we assigned was "the Main Problem in the Family that you would like to work on," asking that they not look at each other's drawings until the sharing time. Father drew Mother abandoning him with the two screaming kids at the supper table, complaining that "She never joins us" **(A)**. Mother drew him reading, while the kids argue and she wearily does the dishes, begging him to intervene in the children's fight **(B)**. Both were shocked by the similarity in their feelings of abandonment and mutual resentment.

Several months later, feeling the continuing tension between the two, we asked them to "draw things the *way you wish they were*." Mother made a picture in which a maid is cooking a meal in the kitchen, while she and her husband have a drink on the sofa. They are romantically planning a trip to Africa, as she thanks him for the beautiful flowers he has sent her. The children are notably absent **(C)**. Father, however, had a very different wishful image. In his picture, his wife is happily cooking the meal, both children at her side. On the other side of his drawing she is sending him to work with a kiss, while the angelic youngsters—complete with halos—wave goodbye from their windows **(D)**. Their conflicting images of perfection and their mutual dissatisfaction, poignantly evident in these drawings, became an increasingly open topic for discussion.

Despite their ability to express how they felt, my co-therapist and I became increasingly frustrated by how effectively this family could rationalize. One day we suggested that they try to draw on the same sheet of paper without talking, a helpful task for highly verbal families. They worked on the drawing for 45 minutes, Mother "taking over" almost half of the space, even adding to the others' pictures. Tim began by drawing a house in the center, but soon gave up and left to work alone with clay at another table **(E)**. He tried to get his father

to join him, and his dad did so for a while **(F)**, but then went back to the table where his wife and daughter were still at work **(G)**.

When all were seated, it was safe for Tim to go up and add some more details to his house **(H)**. For the first time, Mother understood what the others had been trying to tell her about how intrusive and controlling she could be, albeit with loving intentions. The picture—because it so vividly recalled the process—was used by the family, posted on the wall at their request, as a dramatic reminder for many months. It was a visual record of some of the interaction patterns causing stress in the family system.

Family art therapy continued. By the latter part of the work, the focus had shifted from the boy and his now-absent symptom to stresses in the marriage. When it ended, the parents agreed to our recommendation of individual and/or couples therapy, both of which they pursued with positive results. The parents' marriage continued and each of the children went on to become successful adults, earning advanced degrees and functioning at high levels both professionally and personally.

Selecting the best option(s) for any particular therapeutic situation is not that difficult—as long as the clinician's imagination is unclogged, her repertoire is broad, and the purpose is clear. A critical variable in effective therapy is the worker's ability to be open-minded and flexible. For art therapists, this means being sympathetic to a wide range of approaches and materials. The most common modalities in art therapy are the fine arts of drawing, painting, modeling, and constructing—in both two and three dimensions. Since these are well known, the rest of this chapter is devoted to descriptions of several of the many possible variations on the visual arts.

Variations on the Visual Arts

Sandplay

For generations, children have played with *miniature life toys,* and people of all ages have built castles in the sand. Since I always had a sand table in my playroom, the idea of *sandplay* (Kalff, 1980; M. Lowenfeld, 1971, 1979) seemed natural. And although the majority of sand tray devotees are Jungian analysts, the technique itself is used by a variety of practitioners (Bradway et al., 1990; Bradway & McCoard, 1997; Carey, 1999; Homeyer & Sweeney, 1998; Labovitz & Goodwin, 2000; Markell, 2000; McNally, 2001; Mitchell & Friedman, 1994; Ryce-Menuhin, 1992).

Many art therapists, such as Zweig and Caprio (Virshup, 1993), Lusebrink (1990), and Steinhardt (2000), have also found the *sandtray* to be a useful adjunct to their work. On the **DVD (7.4)** you can see Kalff doing sandplay with a child **(A)**, Carolyn Grant Fay doing it with an adult **(B)**, and both talking about the procedure.

Hypnosis and Guided Imagery

One aspect of sandplay is that doing it usually creates a dreamy state of mind. Like most art therapists, I am not trained in clinical hypnosis. But reading fascinating work about painting and modeling while hypnotized (Meares, 1957, 1958, 1960) long ago impressed me with the potential value of creating in an altered state of consciousness. Watkins (1992) devoted a book chapter to what he called "hypnography and sensory hypnoplasty." On the **DVD (7.5)**, Karen Clark-Shock is shown describing her use of both hypnosis and art in what she calls *Hypno-Art Therapy* **(A)** (cf. also Jim Consoli's use of hypnosis in his technique, *Psychimagery* (**DVD 7.1) (I)**.

Approaches to art therapy that use meditation, relaxation, or imagery are closely related, such as the *Guided Imagery in Music* (GIM) technique developed by music therapist Helen Bonny (Bonny & Summer, 2002) and art therapist Joan Kellogg (2002). On the **DVD** Natalie Rogers is shown beginning a session with a new patient by asking her to close her eyes and relax before creating **(B)**.

Phototherapy, Videotherapy, and Computers

Using modern technology, the visual worlds of *Phototherapy* and *Videotherapy* are extensions of the artist's eye, with the camera as the medium. As photographer Alfred Eisenstadt said in a televised interview, "I'd have liked to paint, but I can't paint. I have to paint with my camera!"

Many clinicians have asked patients to bring in *family photographs* (Akeret, 1973). Among them are practitioners such as psychologist and art therapist Judy Weiser (1993) who uses personal snapshots and family albums. On the **DVD (7.6)**, an AIDS patient is seen sharing a photograph of his cats with his art therapist, Ellen Hiltebrand **(A)**.

Robert Wolf[5] **(B)** incorporated *Polaroid photography* in his art therapy with adolescents, who were invited to make cartoon drawings using photographs of themselves and the therapist **(C)**. Two other art therapists introduced what they called *Photo-Art Therapy* (Fryrear & Corbit, 1992a, 1992b), in which they use instant photographs in collage creations. On the **DVD** you can see such a group **(D)**.

From the brief existence of the *International Phototherapy Association* and its newsletter during the 1970s, one might conclude that this visual treatment modality is a form of art therapy, since many of its practitioners ended up settling in AATA. Most prominent is Judy Weiser (1993), director of the PhotoTherapy Centre (**Figure 7.8)**, who has facilitated training and communication **(E)** (www.phototherapy-centre.com). Ellen Horovitz uses photography as well, and has produced a **DVD** about some of the techniques she uses in her work (www.arttxfilms.com).

Figure 7.8 Judy Weiser, PhotoTherapy Centre. © Judy Weiser. Reprinted with permission.

Figure 7.9 Filming for animation.

Film animation, while more complicated, involves art in a very direct way **(DVD 7.7)**. During the 1960s at a hospital in Lausanne, Switzerland, two psychiatrists invited a group of inpatients to make *animated cartoons* using a 16-mm camera. During the 1970s, I became fascinated with simple animation techniques using a Super 8mm camera. I tried them out with several individual children in art therapy at a clinic, as well as with some youngsters who were in "art-awareness" groups in preschools and in a summer program at an elementary school **(Figure 7.9)**. During the 1980s, art therapist Judith Rothschild worked with a group of outpatient adults with chronic mental illness to draw on 16mm film and create animated stories.

On the **DVD** you can see some students setting up **(A)**, doing **(B)**, and filming **(C)** animation. In addition, there is an excerpt from "Dreams So Real" **(D)**, made by filmmaker Oren Rudavsky while he was a student at Oberlin College, about an animation program for patients at an Ohio mental hospital.

Shaun McNiff was one of the first art therapists to explore the usefulness of *videotaping* group art therapy sessions and playing them back to the group. Jerry Fryrear pioneered as well in bringing *media arts* like *videotherapy* (Fryrear & Fleshman, 1981) and *phototherapy* (Krauss & Fryrear, 1983) to the attention of art therapists.

As with viewing the art created in therapy, photography is another way for a person to gain both aesthetic and psychological distance. In *art–drama therapy* groups at the Pittsburgh Child Guidance Center, we often used *slides and films* taken by ourselves or the members **(Figure 7.10)** as a way to re-view and reconsider **(E)**. A film about an adolescent group, *The Green Creature Within* (Irwin & Rubin, 2008), is composed of such photographic records **(F)**. They were also used in the therapy, viewed and discussed like the art, and film was especially useful for recording dramas. But the film needed to be developed, so the visual feedback was necessarily delayed for a week.

Figure 7.10 Filming in an art–drama therapy group.

Video technology, on the other hand, allows instant replay, and is helpful for training and supervision as well as therapy. A combination of art and video therapy is indeed remarkably powerful, as Irene Jakab and I discovered when we conducted some video art therapy family evaluations in the 1980s at a psychiatric hospital. Recent papers and presentations describe using the medium not only for recording and playback, but also as an expressive tool. On the **DVD** you can see some scenes **(DVD 7.8)** from the edited videotape (Jakab, 1982).

For a boy named Isaac, both art and film were central to his therapy as a young child, as an adolescent, as a young adult, and eventually to his life.

Art and Film Therapy Help a Young Man Grow Up: ISAAC (**DVD 7.9**)

I had seen Isaac for five years in child analysis. He was a sad and preoccupied little boy, but took to the use of expressive media with enthusiasm **(Figure 7.11)**. Art and drama were his prime modes of communication throughout his treatment **(A)**. One of his favorite activities was the making of animated films using clay, where the stories he often enacted with his artwork could come alive **(B)**. He made slow and steady progress, but had a hard time ending therapy and saying goodbye when he was 11.

Three years later, Isaac returned for two months of art therapy, saying that he was depressed because he felt rejected by other kids. When he began to express suicidal thoughts, I referred him to a psychiatrist, and we all agreed on hospitalization and a trial of medication. After leaving the hospital, he enrolled in a creative arts high school, where he did a lot of acting and began to make films and videos.

Toward the end of his senior year, Isaac returned once more for art therapy. Deeply discouraged, he had been rejected from all of the colleges to which he had applied. Although he blamed his guidance counselor, he had not applied to a "safety school" as he had been advised. I thought he was probably having a hard time leaving his parents, who were not only angry at him, but also loving and very needy.

Since Isaac was still deeply attached to me as a parental figure, I suggested that he work with an art therapy intern I was supervising at the time. With her assistance, Isaac was able

Figure 7.11 Isaac dramatizing in art therapy.

to overcome his lethargy, find a job, and apply to schools where he had a reasonable chance of being accepted. His dream of becoming a filmmaker helped him to manage the stresses of working and waiting. He also took courses in filmmaking, and began to feel generally more hopeful.

Having made progress in dealing with the outside world, Isaac was then able to use art therapy to deal with his inner world. In his twice-weekly sessions, he was able to get in touch with more of the rage that he had repressed when he was younger. This rage, turned on himself, had been a significant factor in his depression and feelings of worthlessness.

Isaac spent many months working on what he called his "statement." He first sculpted a massive clay head, then covered it with gesso, so that it was literally whitewashed. He displayed it, along with sculptures by other patients, on a round table in my office. Its most outstanding feature was a wide-open mouth, full of carefully sharpened teeth. At one point, he picked up a bloody-looking sculpture by another patient, and placed it inside the devouring mouth, instantly creating a drama **(C)**.

The head was an eloquent symbol of the fears Isaac needed to work through, in order to separate and become a truly autonomous young adult **(Figure 7.12).** He left it as a memento for both of his art therapists, and kept in touch as he made his way through college as a filmmaking major.

At one point he sent me a film he had made and asked for reactions. While it wasn't explicitly autobiographical, Isaac was aware that the drama reflected continuing work on his own wishes and fears. Parts of the film used clay animation, reminding me of his earlier dramas. It seems clear that the arts—in one form or another—will always be Isaac's mode of coping with and contributing to the world. On the **DVD** there is a claymation segment from that film **(D)**.

Computers, like video, are also extremely versatile. They have the ability to do all sorts of creative and colorful things with all kinds of visual elements, both still and in motion. If my experience with a computer-literate intern is any indication, the future holds exciting possibilities for expression. In fact, things are moving so rapidly in that area that a book called *Art Therapy & Computer Technology* is already out of date (Malchiodi, 2000) and is soon to be revised.

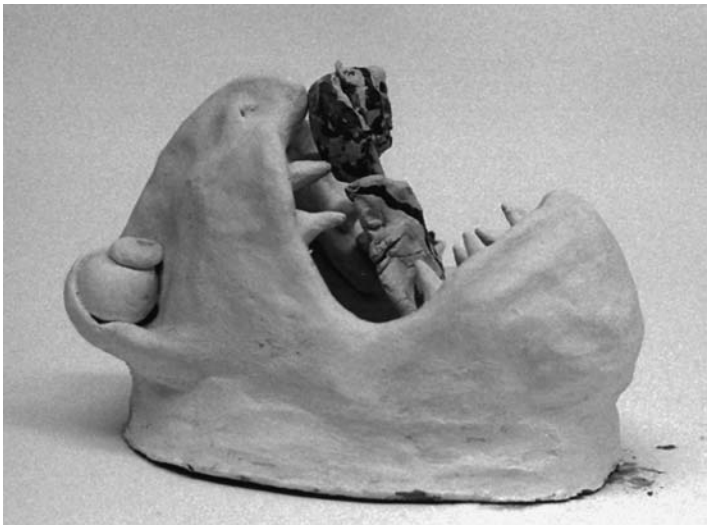

Figure 7.12 Isaac's "Sculpted Head with Victim."

Multimodal Expressive Arts Therapy

The notion that individuals need to find the materials that suit them best is one to which many art therapists subscribe. The related idea—that some media serve certain expressive purposes better than others—is also one with which most art therapists would agree. Since film, video, and animation involve action as well as imagery, they are excellent for the telling of stories. Because they can incorporate art, movement, music, and drama, they lend themselves well to *expressive therapy* (**DVD 7.10**).

Although there are some practitioners who are fluent in several modalities, most art therapists aren't equally facile in other art forms. A few have been trained in two expressive therapies, like Suzanne Lovell who found a deep compatibility between art therapy and the kind of dance therapy called *Authentic Movement* (Virshup, 1993). Lovell's sense of conviction was especially strong, since a combination of the two helped her to successfully combat her own illness (Lovell, 1990). Gong Shu (2004) has similarly integrated her training in psychodrama and art therapy with traditional Chinese healing techniques. On the **DVD** is an art therapy/psychodrama workshop she led **(A)**.

Sometimes two expressive therapists work together, like Norwegian art therapist Ase Minde and British drama therapist Sue Jennings, whose book on *Art Therapy & Dramatherapy* (1993) reflects a respectful collaboration. Although one motivation is the practitioners' interest in learning from one another, it also seems as if more than one modality can sometimes better meet patient needs.

Drama therapist Ellie Irwin **(Figure 7.13)** and I have collaborated on art–drama groups, **(B)** parent play groups, **(C)** and a study comparing responses of the same individuals to art and drama diagnostic interviews. In that research, we found that some themes were more easily expressed in art, and some were more easily expressed in drama—another asset of a multimodal approach (Rubin, 2005a).

Just as it seems to help patients when art therapists are open to collaborating with other clinicians, it also helps when therapists are open-minded, albeit not naively so. Fads and techniques come and go rapidly in the lively world of psychotherapy. All therapists need to

Figure 7.13 Eleanor Irwin, drama therapist.

examine new and potentially helpful adjuncts, especially if they have primary responsibility for treatment.

Linda Cohn's combination of "Art Psychotherapy and Eye Movement Desensitization" (EMDR), which has grown in popularity since she published her chapter, is one such example (Virshup, 1993). Art therapists seem less rigid and doctrinaire as a group than others, perhaps because of the openness that is necessary for a genuine creative process.

I once had the fascinating experience of putting together what I know about art therapy with what Dr. Louis Tinnin was finding out about using video in what he called "Time-Limited Trauma Therapy." Tinnin, a psychiatrist who is also a true believer in art therapy, was using videotaped feedback with clients who had dissociative identity (multiple personality) disorder.

Thanks to his generous sharing of ideas and procedures, I was able to help one of my patients to get to know a number of her *alters* who had so far eluded co-consciousness. She first viewed a videotape of herself in each personality state, made while she was in the hospital. Since she was also taped while watching the first video, she was then able to watch the second tape as well. When we later videotaped the alters drawing and painting as well as talking, the recognition and acceptance of her "parts" was greatly accelerated for the patient. This was a truly multimodal approach, most useful for this hard-to-treat condition. (See the story of Elaine in Chapter 9.)

Concluding Thoughts

I could go on and on, and that in and of itself is the most wonderful thing about technique(s) in art therapy. There are so many different ways of using art to help people. Sometimes they offer possibilities that would be impossible in any other way. For example, time can be collapsed. A *Life Line* of colors and shapes can tell a person's story, and a *Life Space* picture can show how things are at any moment in time.

A *Journal* can be kept in color and line as well as in words, as in a *Doodle Diary*. Relationships can be depicted in three dimensions, as in a *Family Sculpture*. And because you can move three-dimensional forms in space, their dramatized action can further enhance awareness. There is probably no limit to what can be explored and expressed through the rich, wordless medium of art.

And there is similarly no limit to what can be imagined as an approach to helping people through art by the therapist. The source of artistic technique, as noted earlier, is for the art therapist to have digested and assimilated a theory so well that she is then able to respond with disciplined spontaneity. Similarly, the more media and technique(s) she knows about, the greater the menu from which she can choose, as she seeks to provide the most nourishing and most digestible treatment for those she serves.

Deciding how to go about either assessing or treating through art requires a thorough familiarity with artistic resources, as well as with ways of understanding and helping people in pain. The specific fashion in which any art therapist puts them together is the artistry of this work, a source of deep pleasure and continual satisfaction.

Robert Ault cited a metaphoric image of an "*ice skater* … one skate representing art understanding and involvement, the other … representing psychological understanding as well as interpersonal skills."[6] In order to get anywhere, you have *to shift your weight* from one to the other, sometimes pushing off with one and sometimes gliding with both. As Bob wrote, "the skill of the therapist is in the timing, and knowing when to use one or both."

I have often thought of *sailing* as a good metaphor for doing art therapy, since the clinician needs to "catch the wind" when it comes up, often with little notice. There may be long periods of waiting for wind and tides to shift, so that the course of the art therapy voyage can be a safe one. It takes alertness to sense when the patient is ready to move in a new direction—whether in the creative process or in self-understanding.

An art therapist tunes in to multiple frequencies for evidence of readiness to go deeper: artwork, dreams, mood, attitude, and behavior in and out of the sessions. As is true when sailing, there are inevitably rough as well as smooth periods, during which the therapist must hold firm to the rudder, in order to keep the boat of treatment as steady as possible.

Whether the art therapist is seeing an individual, a couple, a family, or a group, whether the goal is assessment or treatment, whatever the age and wherever the setting, the creative challenge of this work consists in deciding what to offer and how to do it. The artistry of the work lies in helping people to become engaged in the creative process in ways that enhance their personal growth.

A good art therapist is selective and sensitive, trying to accomplish the goals of any particular intervention within whatever constraints are present. This may involve using one or another technical approach, but always doing so with the deepest respect for both the materials and the human being(s) involved. Effective and thoughtful art therapy is at least as much an art as it is a science. As in other art forms, only practice can help the practitioner to develop both skill and spontaneity.

As with knowing theory, well-developed technique is not so much a collection of ideas, as it is deeply ingrained and easily available. Elinor Ulman made this point when she wrote that "a little learning may be worse than none. Our understanding must be well digested if it is to inform lightning decisions" (Ulman & Dachinger, 1975, p. 28). A good art therapist, like the gifted and creative psychoanalyst Donald Winnicott (1971a, 1971b), has both theory and technique "in her bones."

Endnotes

1. "Introduction" to the first issue of *Art Psychotherapy*, by E. Harms, 1973.
2. "Utilizing Prestructured Art Elements in Brief Group Art Therapy With Adolescents," by R. Vick, 1999, *Art Therapy, 16*(2), 68–77.
3. Three Perspectives: Framing the Don Jones Assessment (DJA), by D. Jones, M. Vinton, and W. Wernick, 1999, Panel presentation, American Art Therapy Association Conference, Orlando, FL, November 21, 1999.
4. "Drawing Together: Therapeutic Use of the Wish to Merge," by F. F. Kaplan, 1983, *American Journal of Art Therapy, 22*, 79–85.
5. "Art Therapy in a Public School," by R. Wolf, 1973, *American Journal of Art Therapy*, *12*(2), 119–127.
6. Ault, R. E. (1983). Unpublished manuscript.

CHAPTER 8
People We Serve

Just as art therapy can be done in an endless variety of ways for the purpose of diagnosis or treatment, so too there seems to be no limit to those who can be served. Art therapy can indeed be helpful to people of any age level, and with any degree of health or handicap. Its uniqueness, however, lies in its ability to reach people who do not find other forms of help accessible. Whether the condition is temporary, extended, or permanent, there are times when art expression seems to best fill a need.

Art Therapy Is Especially Good For …

Those Who Have No Words

Art may be the only communicative channel for those who cannot speak, whether because of autism, deafness, retardation, brain damage, or dementia. Claire, a deaf-mute girl whose story is told in Chapter 11, could only talk through her drawings. She was eventually able to learn sign language, but never speech. Individuals who do not know the therapist's language—like recent immigrants—can always speak the universal language of color and form.

One of the roots of art therapy, you may recall, was the spontaneous art done by people with incurable mental disorders, whose paintings and drawings were sometimes their only intelligible communications (Prinzhorn, 1922). In a wonderful account of a long treatment, the psychiatrist and the patient describe how art helped Mary Barnes **(Figure 8.1)** to express what she was going through during a massive psychotic regression (Barnes & Berke, 1971; cf. also Barnes & Scott, 1989). Those suffering from chronic mental illness are still well served by art therapy, though they are now more likely to be seen in partial or day treatment programs than in long-term psychiatric settings (Schaverien & Killick, 1997). As one artist eloquently told her interviewer, "art is all the feelings trapped inside."[1]

When I was co-director of a Creative & Expressive Arts Therapy (CEAT) program in a psychiatric hospital, I was impressed by how successful the art therapists were with patients who were admitted in acutely psychotic states. I think there are several reasons for this. One is that creative individuals are likely to think in a more fluid rather than linear fashion. Freud theorized that this was due to a "flexibility of repression,"[2] while more recent thinking has emphasized a reliance on the right (holistic) rather than the left (linear) hemisphere of the brain. Whatever the reason, art therapists are more likely than other mental health

Figure 8.1 Mary Barnes working on a painting.

professionals to be comfortable with the illogical world in which a psychotic person finds himself, as in schizophrenia.

One of the most successful art therapy programs in the CEAT department is a group run by Mary Ann Hayden-Shaughnessy, who has helped those with chronic schizophrenia for many years (**Figure 8.2**). The patients who attend regularly seem to be more compliant in taking medication and in attending psycho-educational groups, both of which allow them to remain more stable. Perhaps Mary Ann's success is due not only to the creative activity itself or the fact that she is an experienced and sensitive therapist, but also to the fact that she herself is an artist.

Artists not only can "understand" primary-process image-talk as noted earlier, but as a group they are more rebellious than conforming, and more isolated than socialized. Art therapists working with colleagues in bureaucratic institutions, however, have had to find sufficient ways of adapting to survive. Therefore, art therapists may be especially able to help those who are atypical to find ways to relate to and live with others, while preserving their individuality and authenticity.

In any case, even highly verbal people of all ages often find that they have no words for certain experiences, especially those that elicit overwhelming feelings. Like Mrs. Lord, who was in such a state of "shock" that she could not talk (Chapter 1), or the family whose fluency masked their feelings (Chapter 7), there are many times when creating visual imagery is far more effective than anything a person might say.

Figure 8.2 Mary Ann Hayden-Shaughnessy.

Those Who Are Resistant

Those who are able to talk, but are resistant to verbal therapy, may be more accessible through art, especially if other avenues have been tried and failed. Despite the anxiety of most adolescents and adults about their artistic abilities, even wary and hostile patients can become engaged if the art activity is presented in a nonthreatening way. Those who are suspicious of verbal therapy and fear that a therapist will "play with their minds," may be more willing to use paint or clay than to talk. Like all elective mutes, Ellen refused to speak, but art was an open avenue of expression. As you will see in the following vignette, it proved to be the key that unlocked her ability to reconnect with her family and eventually to recover.

Art Therapy With an Elective Mute: ELLEN (11)

Ellen had seemed quite normal until the day she got mad at her deaf older sister and stopped talking to her. Shortly after that, she stopped speaking to her alcoholic mother, then to her father, and then to her best friends. By the time she was admitted to Children's Hospital of Pittsburgh for a month of observation, her selective silences had been going on for almost two years. When Ellen refused to return home, she was sent to live with her grandmother, one of the few people to whom she still spoke, on the condition that she come to the Child Guidance Center for psychotherapy.

She had refused to enter the building or to talk to the child psychiatrist assigned to her case, even when he went to her grandmother's car. Ellen was therefore referred for the only nonverbal treatment available—art therapy. I was relieved that she was willing to come to my office, to use some clay (albeit with her back to me), and to draw, facing me as she did so **(DVD 8.1)**.

But when I requested, at the end of her first session, that she leave her picture on a shelf reserved for her, like the others in art therapy, Ellen got very upset. When I asked if we could photocopy it before she left the clinic, she refused, angrily blurting out "You didn't *tell* me!" She walked out rapidly, clutching the drawing tightly to her chest.

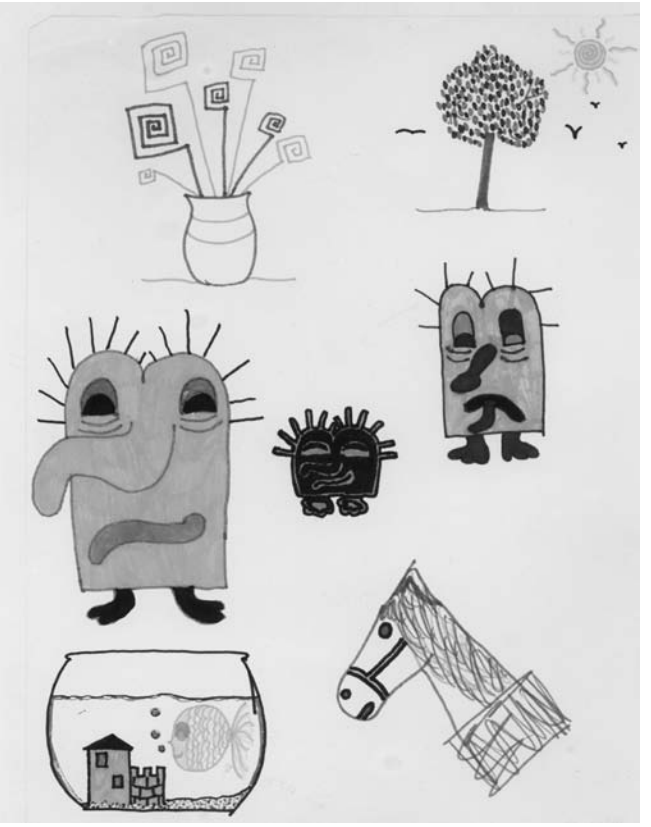

Figure 8.3 Ellen's first drawings of her creature.

Despite this uncomfortable beginning, Ellen seemed to loosen up a bit during the next four sessions. She was interested in my portraits of her doing artwork **(A)**, and was willing to engage in a nonverbal "drawing dialogue," which became fairly intense **(B)**. She even whispered responses to some of my questions about her drawings. I thought we were getting somewhere.

After a six-week interruption—due to vacations and scheduling problems in the Fall—Ellen returned, and created the first versions of what eventually became a rigidly repetitive visual theme. She began her marker drawing with several tight, geometric, linear designs, and then continued on the same paper with a fishbowl, a horse's head, a tree, a geometric flower pot, and finally three creatures in the center, the last with an angry tongue sticking out of a twisted mouth **(C)**. I noted with relief that her posture was more relaxed while she was drawing the creatures (**Figure 8.3**).

In response to my questions, she told me that all three were female. The one on the left was older, the one in the middle was younger, and the one on the right was very angry. Asked who *she* might be in the drawing, Ellen pointed to the fishbowl, then to the horse. I was thrilled that her repressed anger—which is usually behind the stubborn symptom of "elective mutism"—was beginning to emerge.

Ellen spent the following session drawing an enlargement of her odd cephalopod (head-foot) creature **(D)**, while I drew a sad–angry girl with a long nose and prominent eyes, similar to but different from Ellen's creation **(E)**. She said that the girl in her drawing was both happy and sad. The girl in my drawing, Ellen said, was "sick because she's going to the

Figure 8.4 A later drawing by Ellen of her creature.

doctor [who will make her] worse and sicker." She was clearly afraid of this process we had begun, but how fearful I had yet to discover.

From then on, Ellen was stuck on her theme, drawing only variations of it and turning her back to me more and more. Her whispered answers stopped, replaced by head nodding, then silence. As the same creature was drawn week after week **(F)**, month after month **(G)**, Ellen seemed more and more frozen (**Figure 8.4**). Having unsuccessfully tried music, silence, and other maneuvers throughout the Fall and Winter, in mid-February I began to wonder aloud about what was going on, empathizing with her anger and anxiety.

In mid-March, though her therapy-hour behavior was unchanged, her grandmother brought in a book Ellen had made entitled "From Isolation to Involvement." With photographs and poetic text, it seemed a statement of intent. It also included many of the things I had said in our one-way communication system, leading me to hope that perhaps I was getting through after all. Nevertheless, Ellen continued to face me with her back, and to draw the same rigid creature for five more sessions, avoiding eye contact more than ever **(H)**.

The last session in late April began like all the others, but at one point in her drawing Ellen stopped as if immobilized, seeming more openly fearful than usual. I first spoke of, then acted on, an impulse to put my hand on her shoulder. It was close to the end of the hour, and Ellen did not respond. She remained tense and frozen, went on with the picture, and walked out, more rapidly than usual. She went back to her grandmother's and, for the first time in almost a year, telephoned her mother. The purpose of the call was to tell her that she didn't want to come to the clinic anymore "because I don't like Mrs. Rubin."

Although she never opened the note I sent her, and returned no more, Ellen gradually proceeded to go home—first for weekends, and in a few months for good. When I called her mother two and a half years later to follow up, she told me that Ellen had come home warmer and more open than ever in the past, and had done well in school. Most delightful was the fact that this teenager, who had been so frightened of how dangerous her words might be, had become a high school *cheerleader* (!)

Art Therapy Is for All Ages

This chapter is a very general overview of work with people at different age levels, with brief clinical vignettes like the one about Ellen to give the reader a flavor of how art

therapy can work. In addition, the edited video clips on the **DVD** will bring it even more alive for the reader.

Children

There is a widespread notion that art therapy must be used mostly with children, since most adults have more verbal facility and can discuss what's bothering them. There is, of course, some truth in the title of a book about children's art, *They Could Not Talk and So They Drew* (Levick, 1983). But art therapy is actually used more often with adolescents and adults. One of art therapy's greatest assets is that making art comes naturally to youngsters (**Figure 8.5)** and can be helpful in therapy even before a child can work representationally, as in the following example.

Art and Sandplay Help a Grieving Toddler: BILLY (2)

Billy was a two-year-old whose young father had suddenly disappeared. Because he had committed suicide, the family had a harder time than usual dealing with the death, and an even harder time helping poor little puzzled Billy.

As this formerly cheerful, independent boy became increasingly depressed, clingy, and oppositional, his distraught young mother found herself unable to comfort or to control him. Her sister, a therapist, suggested that maybe Billy needed to see someone outside the family, in order to work on his confused feelings and fantasies about his father's death. So he came to see me **(DVD 8.2)**.

Figure 8.5 A preschool child absorbed in creating.

In the beginning Billy spent most of his time at the easel, not speaking and with his back to me. He would paint a blob of color, and then angrily cover it over—compulsively repeating this ritual for many weeks.

Next he turned his attention to the sand table. First he played silently with water and sand, digging, filling, and in general enjoying the sensory experience. Soon, however, he was bringing plastic animals to the sand table, which he would engage in fierce battles with lots of noisy growling **(A)**.

After a few weeks, Billy began to bring rubber human figures to the sand—a boy and a man. They too would fight, and Billy would furiously bury the father figure in the sand, while I would talk about how *angry* he was at his dad for leaving him and his mom so suddenly.

This drama, played and replayed for several months during his weekly sessions, was interspersed with quiet times of painting shapes that were no longer obliterated. Over time, Billy was able to put his feelings into words in the sand stories.

I met several times with Billy's mother, mainly to help her with management issues. As often happens when a parent feels sorry for a child, she was having a hard time setting limits or being consistent. Since Billy already felt some guilt and worry about his anger at his dad and his dad's death, his "power" to intimidate his mother was making him more anxious.

As his mom felt freer to assert her authority, and as Billy became less scared of his powers, she reported that he was no longer oppositional or clingy, but was his old cheerful, agreeable self, coping with his loss by pretending to "be a Daddy" **(B)**.

Art therapy can be helpful at all stages of development. Both Alan (Chapter 1) and Isaac (Chapter 7) were able to use it in early childhood and come back to it later. Paradoxically, art therapy seems to be especially helpful to children at each extreme of the behavioral continuum. A tightly constricted child like Linda (Chapter 5) can become freer, and a chaotic child like Randy (Chapter 1) can become more organized. An oppositional child like Jack (Chapter 1) can sublimate his aggression in clay, and a timid child like Don (Chapter 5) can explore freer behavior by using fluid media, then by safely expressing his "scary mad wishes" in sculptures that cannot hurt.

All kinds of children can be helped because the process of creating with art materials requires both spontaneity and control. Thus, children who are treated with art therapy not only span a wide age range, but also an even wider range of problems. A boy with a developmental or cognitive disorder like Randy (Chapter 1) can use art to organize his thoughts as well as to express them. An anxious child like Carla (Chapter 2) can picture her fears and end her nightmares. A depressed child like Lori (Chapter 1) can work through her feelings about loss through art and play. Parents and children who are having problems can see interaction patterns more easily on a piece of paper than in words, like John and his mother in Chapter 5 or the family in Chapter 7.

As you just saw with Billy, even a two-year-old can benefit from expressive therapy. He of course had suffered a sudden and traumatic loss, and his father's suicide no doubt made it hard for his mother to help him. It was good for both of them that she sought treatment.

In contrast, in the vignette below, Amy's parents were both warm and loving, and she had been developing smoothly until age three, when, with no major trauma like a death, she suddenly started to have nightmares and to wet her bed. Her mother knew the parent of another child I had seen when he was four (Alan, in Chapter 1), and after assessing the situation I recommended art and play therapy, which proved to work well and quickly. Here is a summary of her story.

Figure 8.6 Amy in art and play therapy.

Art and Play Therapy for an Anxious Little Girl: AMY (3) (**DVD 8.10**)

Amy was an adorable little girl who had been quite cheerful and well-adjusted until she started to wet her bed and to have scary dreams. Her mom had recently gone back to work, and worried that Amy was missing her. Her separation anxiety had indeed escalated, but behind it were very mixed-up feelings, because when Mommy went on business trips, Amy got to be alone with Daddy, which felt both good and bad. In fact, it felt great to pretend to be the mommy, but it frightened Amy that her scary-mad wish (to "get rid" of her mother) seemed to have come true.

She was very bossy and competitive with me, often reversing our roles in dramatic play. She liked both dramatic play **(A)** and art **(B)**. But the biggest breakthrough came after she drew what she called her "favorite picture" **(C)**.

When Amy made the drawing, her mom had just returned from a trip, and Amy was mighty relieved. The picture was of a king and a queen, happily beaming at their little girl, the princess. Amy announced that the princess was going to a ball, where she would meet a man named Prince Charming, that they would soon be getting married, and that they would live in their own castle **(Figure 8.6)**. Her symptoms gradually subsided, and she was soon able to finish her therapy. The pivotal drawing represented her acceptance that her father's mate was her mother, even if when she traveled Amy had Dad all to herself. In psychoanalytic terms, she had resolved the Oedipus complex.

Many different approaches (Rosal, 1996) are used in art therapy with children, including Freudian psychoanalytic (Case & Dalley, 1990, 2008; Kramer, 1958, 1971, 1979, 2000; Naumburg, 1947; Rubin, 2000b), Jungian (Allan, 1988; Furth, 2002; Jeffrey, 1995), Gestalt (Oaklander, 1988), solution-oriented (Gat, 2003), and phenomenological (Betensky, 1973, 1995). There are also therapists who use psycho-educational approaches, though because these tend to be more common with children who have disabilities, they will be described in the next chapter.

Adolescents

Teenagers, who are normally narcissistic, tend to be extremely interested in themselves and, by extension, their creations (**Figure 8.7**). Although it is usually necessary to deal with their

Figure 8.7 An adolescent doing rug hooking.

anxieties about performance and about the therapist "seeing through" them, art therapy is a fine avenue for the developmental task of identity formation.

Art is also one way to make relatively uncensored self-statements, since every creation is a self-representation, even when it is not so identified. Exploring media, finding out what you like and what you don't, what is comfortable and what is not, are all fairly non-threatening forms of self-definition. Developing a personal style, so important to adolescents in dress and grooming, can be explored without embarrassment in the area of artistic style.

Normal adolescence is a period of rapid physiological change, creating confusion and concern about body image. Overwhelming and sometimes disorganizing feelings, along with sudden mood shifts, are also characteristic of this hormonally fluid period of life. Art offers a safe way to deal with such transformations, as was true for Betty Jane whose story you heard in Chapter 1.

Defining the self in relation to the peer group is another major developmental task. Creating alongside other teenagers about common themes like friends, or working together on art projects like murals, are some of the many ways to deal with relationships through art therapy. Adolescence is also a time to redefine one's role in the family, and family art therapy can help all members adjust to the changing equilibrium.

Most books about art therapy with children also include work with preadolescent and adolescent youngsters. In addition, adolescent art therapy per se has been the focus of several books written or edited by those who treat teenagers (Camilleri, 2007; Linesch, 1988; Moon, 1998; Stepney, 2001; Riley, 1999).

There are also some detailed case studies, like Margaret Naumburg's (1950) work with Harriet or Helen Landgarten's (1981) with Lori. As is true for young children, adolescents seen in art therapy suffer from a wide variety of disorders—including depression, phobias, eating disorders, addictions, other problems with impulse control, and conflicts with authority.

Because adolescents are in the process of separating from their parents, they are often more resistant to therapy than other age groups, unless they themselves have requested it. For that reason, art may be more acceptable than verbal therapy, since the demand to talk about problems is reduced and there can be pleasure and discharge in using materials once anxieties about performance are overcome.

Adolescents are more inhibited about using art media and talking about their work than younger children, because unless they have continued to study art, they feel inadequate as artists. Like reluctant adults, they need to be helped by the therapist to understand why and how using art can help them to understand their problems more rapidly.

Art Therapy for a Painfully Shy Adolescent: LUCY (13)

From the time of her parents' divorce when she was three, Lucy had been a terribly timid child. Forced by a judge to move to her father's after a traumatic custody battle at age 12, she became increasingly withdrawn and depressed. By the time she was brought for the therapy that had also been ordered by the court, Lucy was justifiably suspicious because the psychologist with whom she had met for the custody evaluation had not honored her stated wish to remain at home with her mother and brother.

Since she was so reluctant to speak, it was fortunate for both of us that Lucy was willing to try using art materials and that she liked doing so **(DVD 8.4)**. She began by carefully modeling tiny clay creatures, just a few inches high **(A)**. Though she worked in silence, Lucy was willing to talk for the figures in response to my questions, as if they were puppets. The little figures began to softly voice the angry feelings she had turned on herself, causing her depression.

After a few months, Lucy began to experiment with other media, like chalk, crayons, and all kinds of paints **(B)**. She told me a great deal about her fantasy life in powerfully poignant paintings and poetry, long before she was able to speak freely and directly about her feelings.

She gradually adjusted to her new school, and became involved with a group of giggly girlfriends. After a year of weekly art therapy, Lucy was less depressed and more assertive—no longer terrified of her intense feelings—no longer frozen in silence. Although her father thought that she was so much better that therapy was no longer necessary, Lucy—who had been too afraid of her dad's temper to oppose him in the past—was able to speak up and to say that she wasn't ready to stop. She came for another year, and began to confront her more deeply buried fears and fantasies.

The Story of Sam: A Schizoid Teenager (18)

Sam, oversized (six feet nine inches tall), overweight, and extremely bright, had dropped out of school, and had literally locked himself in his room before coming to the clinic. He had been in individual and family therapy for several months, and was referred to an adolescent art–drama group, partly because he was talented in art (Rubin, 2005b). After seeing Sam for individual drama and art assessment interviews, Dr. Irwin and I thought that this kind of group might be especially appropriate for Sam. He had withdrawn completely from peers, and we felt he would only be able to tolerate a kind of group therapy where he could work individually until he was ready to interact with other members. This, in fact, is exactly what happened **(DVD 8.5)**.

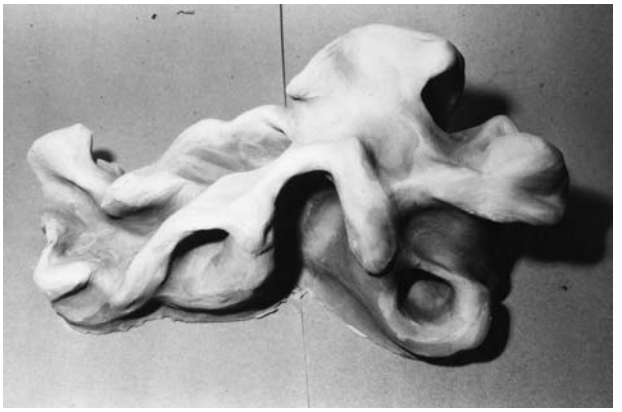

Figure 8.8 One of Sam's abstract sculptures.

In the group, he began by isolating himself behind an easel in a corner and working on a series of brightly colored, organic, curvy, voluptuous paintings. During those early months, his work in clay was equally soft, undulating and fluid **(Figure 8.8)**. But in the fourth month, for the first time he played a role in a drama—that of a defense attorney, where his debating experience enabled him to be verbally aggressive and competitive.

His artwork around this time started to gradually change, extensions emerging from the clay, projections thrusting out from the flowing masses. In his paintings, too, there were more often clearly separated parts, shapes, and colors, becoming more varied and differentiated. Gradually he began to try other media, like wood, which gave his creations even more form, stability and power.

As though a structure was forming internally as well, Sam began in minute, playful ways to display some of the anger he had always repressed. After about a year of group therapy, he spontaneously created a vivid, powerful drama that seemed to represent the psychic awakening he was experiencing.

Saying that he was playing a "crazy person," Sam cowered fearfully, retreated inside a womblike enclosure (a large wooden box), and pulled it out the door. Opening the door brusquely, he walked back in, appearing to be a totally different person, stomping and speaking loudly, angrily, and strongly: "Where is that fellow? That other fellow who is so scared all the time? If you see him again, tell him to get out of here!"

He repeated the drama the following week, after proudly reporting the sale of one of his paintings for $25 to a local bank. This time he involved the other two leaders in the story but had some difficulty being assertive with them. He dressed Dr. Irwin as a witch and Dr. Borrero as a king, then struggled in pantomime with these powerful parent figures. He was able to win out with the witch-mother but often weakened in his battle with the king-father.

Since Sam was unable to use words to express his anger at the male leader, we suggested he try numbers. He was then able to carry on an intense, angry dialogue, with dramatic intonation and affect. The outcome was a compromise, in which a third Sam finally emerged, not the violently angry one or the fearful cowering one, but a strong, reasonable (integrated) self.

Simultaneously, his artwork began to change dramatically. He began to move from abstraction to representation, sometimes even making people—faces that were often

Figure 8.9 One of Sam's figurative paintings.

distorted and grotesque **(Figure 8.9)**, perhaps representing some of those long-repressed inner feelings **(A)**. The same damaged self was in a story Sam had told several months earlier, after a brief hospitalization and some regression. He described a Martian invasion and an Earthling, clearly a self-image, about whom he then felt almost hopeless:

"About this time, one of the most primitive of the Earthling creatures wanders to the far side of the ship, and is immediately stranded, unable to get back. The Martian scanner analyzer at this time determines that the earth creature doesn't have enough life support system. The Earthling creature will die. The Martians will have to intervene to save his life … The elevator hydraulic on the lift is raised, and three Martians go out to rescue the primitive Earthling, who is now dying.

"This is a great victory for the Martians, as they can now examine an Earthling, and now they can condition it, and can observe very closely its behavior patterns. The only disadvantage for the Earthling is that he'll find out … Another disadvantage for the Earthling is that there is intense physical pain in the cranial brain area … The Earthlings are very weak creatures. The Earthlings must realize that the Martians are omnipotent. They are not only superior but omnipotent. However, the Martians respect the Earthlings for their ability to grasp *some* information, and find that the Earthlings could no doubt be developed into an intelligent lifelike form. The end."

Dr. Irwin, to whom he told the story, asked: "You mean there's some hope for the Earthlings?" Sam replied slowly, "Well, some hope … rather remote. At times it seems nonexistent, but there is *some* hope." His characterizations of himself and the leaders reflected both his fears and his hopes for change through therapy.

Change for Sam, as for all, was often slow, with regression as well as progression over time. Becoming aware of all of his feelings, happy as well as sad ones, he struggled to integrate

this newfound awareness of his inner life. As he became stronger, he related more and more to the others, developing genuine friendships such as those he later formed in college. One of his favorite creations was a powerful phallic head of a king, symbolizing perhaps the strength he was beginning to realize in himself. On the **DVD** you can see Sam's story from the film about the group, *The Green Creature Within* **(B)**.

Through the leaders and the other group members, Sam was able to grow in remarkable ways. When the group ended after two years, Sam continued in individual art therapy until shortly before he left for college. His letters from school were full of humor, and sometimes included drawings, like a view from his window **(C)**, which were far more realistic than what he had done in group. In college Sam was not only academically successful, but went on to a highly responsible international position where he could comfortably use his extensive linguistic knowledge.

Adults

While most adults are reluctant to use art materials at first, many can be helped to do so when the activity is explained as another way to work on their problems, and one that may speed up the process (**Figure 8.10**). Art therapy is also appealing to normal adults who want to improve the quality of their lives, whose goal is not so much symptom relief as it is personal growth. Identity formation is a task that continues as people go through the life cycle, as in the story of Laurie in Chapter 4 or Gloria in Chapter 7.

Using art materials, parents can draw about their children, and couples can deal with their relationships—like Mr. and Mrs. T. in Chapter 1. In fact, people can represent practically

Figure 8.10 A woman beginning a self-portrait.

Figure 8.11 A man working with clay.

anything in art—from abstract ideas like freedom to feeling-states like panic. Art therapists treat adults with a wide range of problems, including personality disorders, anxiety disorders, and problems in adjustment (**Figure 8.11**). Because images can bypass verbal censorship, art therapy is especially helpful for those who use words defensively, like Laurie in Chapter 4 and the family in Chapter 7.

While the majority of art therapists see adults, and much of the literature describes work with people in the middle phase of life, only one book deals specifically with *Adult Art Therapy* (Landgarten & Lubbers, 1991). Pioneer Margaret Naumburg's seminal books that followed her early work with children (1950, 1953, 1966) all include detailed case studies of individuals in both young and middle adulthood. Like Freud, Naumburg was a good writer, and these stories still read so well that they remind me of the title of a book by a Gestalt therapist, *Every Person's Life Is Worth a Novel* (Polster, 1990).

Other fascinating stories of people whose art was central to their therapy are told by Baynes (1961), Harding (1965), Meares (1957), and Milner (1969). Like the account of a woman who emerged from a psychotic regression in part via art (Barnes & Berke, 1971), there is another fascinating story told by both the patient and the therapist (Dalley, Rifkind, & Terry, 1993; Cf. Also Naevestad, 1979).

Art in Diagnosis and Therapy with a Young Adult: SALLY (22)

Sally was a graduate student in musicology and had always been an outstanding performer. But when she confessed to her advisor that she was having a very hard time getting her work

Figure 8.12 One of Sally's powerful paintings.

done, he suggested that she see a therapist. Because Sally was articulate and very high functioning in both her academic work and her part-time job singing at a church, my first impression was that she was having an adjustment reaction to being so far away from home. After several months of therapy, however, she was still quite depressed and behind in her studies.

She was so full of things that pressed to be conveyed, I simply let her words flow to relieve the pressure. Being in my space, however, she was aware of the art materials and the table with others' sculptures on it and had commented on some of the pieces. One day I wondered if she had ever tried painting or drawing, and Sally said that she had loved art when she was little, but that she was sure she was "no good" at it now. Assured that the art was for therapy and not for show, she was able to start experimenting at home, a suggestion I sometimes made for those who were inhibited about creating in front of me. When she brought in her first drawings and paintings **(Figure 8.12)**, I was astonished **(DVD 8.6)**.

Not only were they beautiful, they also revealed the extent of her well-masked pathology, which included occasional paranoid delusions **(A)**. Thanks to the clues in her artwork **(B)**, Sally was able to be placed on medication for her mood disorder before she had any psychotic episodes. Thanks to her hard work in therapy, accelerated by what she learned from her artwork, she was able to finish her degree program. Sally's art became a welcome outlet at times of stress. When she left for a job in another city, her parting gifts were framed paintings and permission to tell her story.

Unresolved Grief Finally Faced: OLIVER (36)

Although Oliver lost his mother when he was only six, his aloof and grief-stricken father was unaware of his son's withdrawal. Because of this early loss, Oliver's problems as an adult brought him to a series of therapists, as he struggled to work through all of the confused feelings within. Only then could he give up self-destructive behaviors, which he had tried to use, in vain, to cope with his pain.

In his thirties, Oliver sought therapy for his pervasive depression and persistent problems with women **(DVD 8.7)**. After several months, he shared with me his adolescent sketchbooks, in which he had continued to grapple with his mother's death. His drawing of a lonely

Figure 8.13 A lonely boy looking out a window.

young man—feeling alienated and staring sadly out the window—(**Figure 8.13)** showed his inner state of painful isolation **(A)**.

The one genuine human bond Oliver had—with his mother—was repeatedly torn, first by the birth of his sister when he was four, then by his mother's illness, which led to many separations, and finally by her death from cancer. His last memories of her were of her face framed in a hospital window, echoing his self-portrait.

Death was present on many pages of his sketchbook, even in otherwise peaceful scenes. Oliver searched vainly for a passionate, instant "love at first sight"—the adult equivalent of mother–infant bonding.

He looked for a woman so strong that he could never be hurt, like an aloof "superwoman" (**Figure 8.14)** he drew early in treatment **(B)**. Sadly, because of the "repetition compulsion," he was attracted to distant, unavailable women—far away like his dad and cold like his mom. The end of a relationship with one such "Snow Queen" plunged him into the despair for which he sought therapy. Significantly, he did not return to the male therapist he had seen some years before, but sought a woman, going first to his lover's analyst who then referred him to me.

Though not consciously planned, the transfer involved a reliving of the same loss he had felt as a child when his mother died, to be replaced first by his grandmother, then by a stepmother when his father remarried eight years later. It was only when Oliver returned for

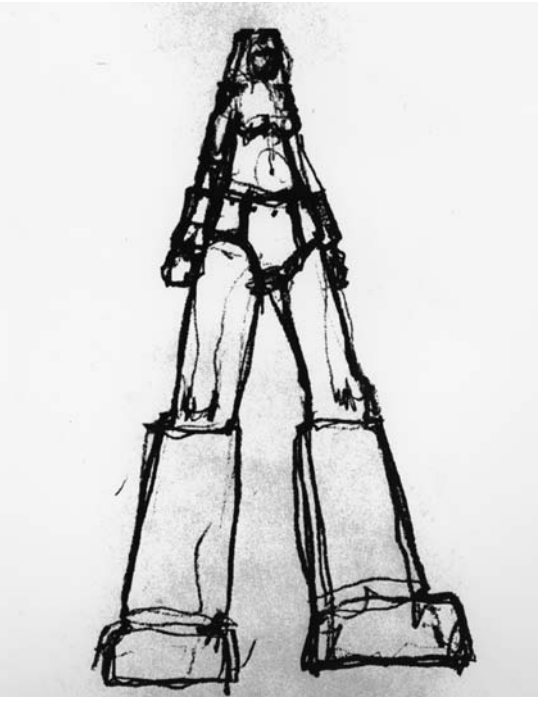

Figure 8.14 A superwoman.

further work later on that we could begin to deal with his hurt by the analyst and his rage at me for not being her.

It was only then that he could tell me how angry he was that I had not realized the extent of his alcoholism, which he had minimized, just as he had hidden his pain from his father. Fortunately, he had met a woman shortly after his first two-year period of therapy whose concern helped him to finally go into rehabilitation.

After completing the program, becoming a father, and marrying the woman, Oliver returned for further therapy. This time he was able to express feelings he had hidden from me, especially hurt and anger. On many levels, it was clear that along with his physiological vulnerability, his addiction had been a classic instance of the search for "mommy in a bottle."

Art Therapy for Artists

You might wonder whether art is an especially appropriate form of therapy for artists. Most artists feel that their own art has been therapeutic for them, especially at times of stress (Birkhauser, 1991; Sherman, 1994; Spencer, 1997). Many individuals have decided to become art therapists because making art helped them to get through some serious crisis in their own lives.

Some artists fear that any kind of psychotherapy will rob them of inspiration, but the evidence is to the contrary (Kubie, 1958). Jackson Pollock's drawings and paintings were used extensively in his analysis, and may have accelerated the treatment (Wysuph, 1970). Many art therapists have treated artists through art, like Josef Garai who helped a painter to resolve "identity conflicts" (Ulman & Dachinger, 1975). Dissolving creative work blocks, a subject often mentioned by Margaret Naumburg, is sometimes the goal of art therapy (Landgarten, 1981).

The Elderly

The focus of most art therapy literature about work with adults is not on developmental issues, but rather on specific conditions. Conversely, art therapy with the elderly, an area that has grown in recent years along with the changing demographics of our population, tends to focus on aspects of aging, per se, a normal condition for all human beings. As I discovered in my own life, aging truly creeps up on you. The changes are for the most part gradual and subtle. At around the time I was writing the first edition of this book, I had been invited to deliver a presentation at a university conference on the elderly. My assigned topic was art therapy for older adults.

While I was thinking about preparing for that lecture, I was on a sightseeing boat in the San Francisco harbor with my grandson Ben who was then five years old. I watched him interact with a family on the other side of the deck, and with a startle, listened to him say as he pointed to me, "See that old lady? That's my Nana."

The truth is that I hadn't thought of myself as an "old lady," but Ben was a more objective judge than I. I was already a member of AARP and within a few years of being on Medicare. Despite the fact that I had taken up tap dancing at age 62, my body had in truth developed a number of new "conditions," with ominous names like hypertension, atrial fibrillation, spinal stenosis, and emphysema. So despite my denial of being "old," I have, like all of my friends, had to learn about the importance of acknowledging the changes and challenges of getting older. As Bette Davis said, it's "not for sissies."

People are living longer lives these days, and despite those who want to look only on the bright side, aging carries with it inevitable and potentially painful losses—of people, position, role, resources, and faculties. Depression is common, and art therapy can be a powerful modality for *Railing Against the Rush of Years* (Ridker & Savage, 1996). In fact, the power of creative activities to enhance and improve our lives is finally being confirmed by well-designed studies (Cohen, 2001, 2007).

It was not always so. When I first consulted to nursing homes in the 1960s, if there was any art at all for their elderly occupants it was limited to such impersonal tasks as making pot holders or filling in paint-by-number pictures. Like the long-term state hospital patients I watched pouring clay into molds, the elderly were thought to be incapable of creating personally meaningful art (**Figure 8.15)**. While preformed approaches may indeed guarantee "successful" products, they do so at the expense of personal expression. Worse, they do not permit an authentic experience of mastery, which is especially vital when so many formerly intact faculties are ebbing.

Although some prejudices still exist, they have been successfully challenged by those art educators and art therapists who have seen beyond the limitations of older adults to their capacity for genuinely creative work (**Figure 8.16)**. Whether to touch the past in "life review," or as a way to find order in the changing present—art can be a veritable lifeline for those whose world has shrunk, and whose days have become heavy with empty time. The sensory aspects of art materials provide pleasure in contact. There is also a sense of pride in having formed something new and beautiful. Art is one way to fill the need for "vital involvement in old age" (Erikson et al., 1986).

A few art educators pioneered in bringing art to the elderly (Greenberg, 1987; Hoffman et al., 1980). Art therapy pioneers included Dewdney (Ulman & Levy, 1981) and Zeiger, who used the technique of *Life Review* (Ulman & Dachinger, 1975). Weiss (1984) published an eloquent pictorial essay, and later a book. And Jungels described her work on film (1980) and in writing. Wald wrote about art therapy with those suffering organic impairment (Wadeson

Figure 8.15 An elderly woman painting in a nursing home.

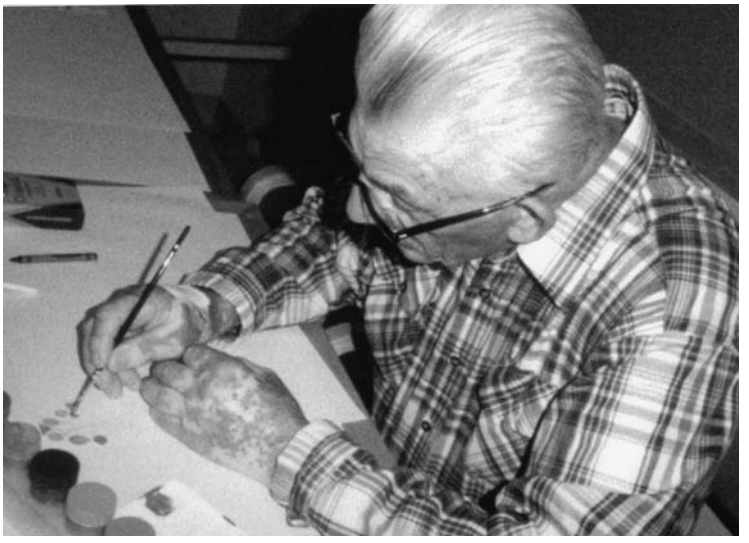

Figure 8.16 An older man painting in a hospital.

et al., 1989) and two other art therapists published a guide to drawing and writing for older adults (Rugh & Ringold, 1989; cf. also Fausek, 1997).

About 10 years before Ben helped me to acknowledge my own aging process, I worked with a woman in her early sixties. The psychiatrist who had referred her expressed the then-common concern that a person her age might not be flexible enough to change in psychotherapy, but that it was worth a try. It turned out to be surprisingly successful. While I was finishing this revision, almost 20 years after our work together, I ran into her at a play, and she introduced me to her husband as "the woman who helped me so much in therapy." Now

81, despite some significant health problems, she seemed genuinely optimistic about herself and life, and clearly enjoyed the chance encounter.

It's Never Too Late: HANNAH (64)

For Hannah, a woman in her sixties who had been sexually abused by a family friend as a little girl, and who had been subtly rejected by her mother, her first foray into therapy was an anxiety-provoking event. She had come because one of her sons had gotten into drugs, and seemed to be on a self-destructive collision course. Like many mothers, she worried that she herself had been the cause.

Hannah was also restless, now that her children had left home and she was alone with her workaholic husband. She was unhappy about herself and with her own lack of direction, feeling that she had played roles defined by others all of her life. Although she couldn't say it, Hannah was really yearning for a sense of Self, wanting to find her inner voice **(DVD 8.8)**.

Frustrated by the short time span of a regular session (45 minutes), since it took her the better part of it to "warm up," she had asked for a double session, which had worked out well. Invited to use art materials, she made a powerful clay head of a dog, and said it looked "very sad" to her **(A)**. We both saw it as a self-portrait, reflecting her discouraged state. Then, using a scribble as a "starter," she drew a pained head, mouth wide open **(B)**. It conveyed how "hungry" she was, not so much for the extra time she had requested, but for what it symbolized—maternal love.

After a year of such weekly meetings, Hannah announced with pride that she thought she was ready to leave. She kept in touch for a time, with cards and the gift of a book about a talented child artist from another country. In therapy, she had what she experienced as a new beginning, in which my nonjudgmental acceptance of her and pleasure in her timid steps toward self-definition—which included trying art materials—enabled her to grow, at a point in her life where she had almost lost hope.

Elizabeth "Grandma" Layton's story shows that it is never too late for art, and that it can have amazing healing powers. This Kansas housewife overcame a lifelong depression at age 68—by making contour drawings of herself and her concerns—a technique she learned in an art class (**DVD 8.9**).

The 82-year-old artist testified on a videotape played at Senate hearings on the *Older Americans Act* in 1992, while her drawings were on exhibit at the Smithsonian Museum (cf. Lambert, 1995; Nichols & Garrett, 1995). Her story was also told at the hearings by art therapist Robert Ault (1986), and it was so moving that art therapy was included in the regulations as a supportive service (**Figure 8.17**). Four years later, successful lobbying led to the inclusion of the arts therapies in the regulations for *Day Treatment Programs*, which often serve the elderly.

Beyond Words: Art Therapy for Older Adults (Rubin, 2008a) was first made to promote art therapy to legislators in 2004. It has been revised, and is now available with added features. These include an introduction to the film as well as excerpts from two other films on art therapy with older adults: *Make Your Mark With Art* (about *Wheel Art,* done using wheelchairs) and *Portrait of Pleasure Endeavors,* about a program at a California hospital. In addition, *Anna Shafer & Her Art,* a charming film based on an interview with an 85-year-old artist (Jungels, 1980), is also on the **DVD** available from EMI (www.expressivemedia.org). A three-minute excerpt from *Beyond Words* is included on the **DVD** that comes with this book (**DVD 8.10**).

One of the most promising developments has come from a well-designed study by Gene Cohen, a psychiatrist and gerontologist who is director of the Center on Aging, Health, &

Figure 8.17 "I'm Into Art Therapy" by Elizabeth Layton.

Humanities at the George Washington University Medical Center (Cohen, 2001, 2007). The therapeutic power of the arts has been dramatically demonstrated by the Creativity and Aging Study, which has examined "the influence of participatory art programs on the general health, mental health, and social activities of older people."[3]

Only a year into the two-year study in which matched groups of elders were assessed on a variety of measures, it was clear that those involved in the arts programs were benefiting. They had better overall health, fewer doctor visits, lower medication usage, fewer falls, less loneliness, better morale, and were involved in more activities.[4] The data confirm what artists, art educators, and art therapists have known for so long: that being involved in the exciting and rewarding activity of making art improves health and prevents illness.

Parenthetically, art can help in assessment too, since drawings may show the extent and nature of organic impairment. Both the diagnostic and the therapeutic value of art therapy for older adults are described by a group of experienced authors who have worked with this population (Magniant, 2004). *When Words Have Lost Their Meaning* (Abraham, 2004) is by an Israeli art therapist who worked with those suffering from Alzheimer's disease, a loss of the self that is painful for both individuals and their families.

But even when there are no more words, there is still the capacity to respond to one of the nonverbal art forms, music. Mala Betensky, a brilliant art therapist who wrote two wonderful books about her work with children (1973, 1995) ended her life in a residence for those with Alzheimer's. A proud woman, she was aware of her deteriorating condition when the disease began, and would not let me come to visit because she was ashamed. Her daughter, however, visited until the end. At the funeral she spoke with warmth of how the activity that most calmed her mother in her final days was listening to Yiddish lullabies that she had sung to Aya when she was a little girl.

In another interesting story reported in the press, residents of a nursing home were taken to a museum to look at the artwork. The docents explained, as usual, things about the history and the artists. What was unexpected, however, was that some of the elderly viewers

began to talk about their responses to the paintings in language that was more extensive and more coherent than they were usually capable of using.[5]

Although the explanation for this phenomenon will no doubt someday be found in brain imaging studies as increasingly sophisticated technology becomes available, something quite amazing happened when these presumably regressed elders looked at art. As with Mala Betensky, the power of the arts to calm and to stimulate the older mind is not limited to producing but also to receiving. According to a 2005 article in the *New York Times*, short focused tours for Alzheimer's patients were being offered at the Museum of Modern Art in New York City, the Museum of Fine Arts in Boston, and others.

The Hebrew Home and Hospital for the Aged in Riverdale, New York, has long known about the value of seeing as well as creating, and has had a curator of art, which is exhibited on its walls, as well as an art therapist. On the **DVD (8.11)**, you can see an excerpt from a television program about that two-faceted involvement in the visual arts.

Parenthetically, you may remember that art therapy always involves both doing and reflecting, perhaps intuitively tapping into the value of both expression and perception for the human psyche.

One more story … Margaret Naumburg, the grandmother of art therapy, and a brilliant woman like Mala Betensky, ultimately lived a very long life. Toward the end, she too began to lose her mental faculties. It was a blessing, however, that she did not seem to be aware of the decline. In my last visits to her, in connection with interviewing her for a film on art therapy pioneers, she asked me to look over a manuscript she had been working on. When I read it, I realized that it was actually a fairly jumbled version of her first book. Not only was she unaware, but what was also impressive to me is that part of what she was doing instinctively to cope with being confused, and by then in her nineties, was to create, as best she could.

That drive to express and externalize the self, whether in words or sounds or images, is so strong in human beings that it seems quite primal as well as quite powerful. As I was rewriting this book, a gentleman in his nineties, whose art I had long admired, died. Jimmy Lee Sudduth was a farmer who created art from natural materials, using mud and water to make paint and leaves and berries to add color **(DVD 8.12)**. Although he became quite well known as an "outsider" or self-taught artist during the 1980s when that kind of art began to be popular, he created not in order to sell or to exhibit, but rather because it was a compelling urge **(A)**.

Like Howard Finster **(B)**, another self-taught artist who was profiled in a book and film entitled *Passionate Visions* (Yelen, 1995), Jimmy Lee Sudduth found painting to be a powerfully engrossing and deeply fulfilling activity. It is probably not accidental that many such folk artists are in their later years. Some of the recent research cited by Gene Cohen (2001, 2007) suggests that the very fact of a dementia in old age frees the capacity to create. Willem de Kooning, for example, became even more productive as an artist when he developed Alzheimer's disease.

In fact, I can think of no better words than Jimmy Lee's with which to close this chapter: "When I first started I was three years old. If I couldn't paint I'd just be lost! I don't believe I'd live long. I believe I'd just die. If I couldn't paint nothing—I just got to be where I can paint something! I paint something all the time."

Endnotes

1. "Art is all the feelings trapped inside: An interview with Marilyn McKeown," by S. Spaniol, 1995, *Art Therapy, 12*, 227.
2. Freud, S. (1908) "Creative Writers and Day-Dreaming," *Standard Edition*, Vol. 9, 1908, 141–156.
3. "Research on Creativity and Aging: The Positive Impact of the Arts on Health and Illness," by G. D. Cohen, 2006, *Generations, 30*(1), 10.
4. "The Impact of Professionally Conducted Cultural Programs on the Physical Health, Mental Health, and Social Functioning of Older Adults," by G. D. Cohn et al., 2006, *The Gerontologist, 46* (6), 726–734.
5. Kennedy, R. "The Pablo Picasso Alzheimer's Therapy, by R. Kennedy, 2005, *New York Times.* October 30, http://www.nytimes.com/2005/10/30/arts/design/30kenn.html#.

CHAPTER 9

Problems We Address

Wherever there is a spark of human spirit—no matter how dim it may be—it is our sacred responsibility as humans, teachers, and [therapists] to fan it into whatever flame it conceivably may develop… .We are all by nature more or less endowed with intrinsic qualities, and no one has the right to draw a demarcation line which divides human beings into those who should receive all possible attention in their development and those who are not worth all our eἀorts. One of these intrinsic qualities is that every human being is endowed with a creative spirit.

Viktor Lowenfeld

Living With Mental Illness

Introduction

Art therapy cannot *cure* psychotic disorders. If they are chronic, the person is fortunate to find a medication that helps to keep the condition under control. As noted earlier, those with chronic mental illness were the first to "speak" through art, alerting psychiatrists to what was going on inside them (Prinzhorn, 1922). If the breakdown is temporary, like the experience of Canadian artist William Kurelek, then the story can have a happy ending (Adamson, 1984). Kurelek ended up in one of the first art therapy studios, that of Edward Adamson at Netherne Hospital in England. He found his way out of madness through painting, and his story was told in the film *The Maze*. On the **DVD (9.1)**, you can hear about some of what happened from Kurelek himself, as he discusses one of the many powerful paintings he created during his illness.

A Story of Bravery and Creative Coping: KAREN

While I was working on the adolescent unit at Western Psychiatric Institute and Clinic (WPIC) in the early 1980s, a depressed girl named Karen was admitted after a suicide gesture. She was unwilling to talk to anyone, although she was not mute. She came to an art therapy group and discovered that art allowed her to say things she couldn't put into words. She asked the physician in charge of her treatment if she could have individual art therapy as well and he agreed **(DVD 9.2)**.

We met several times a week and Karen began to warm up to me, as well as to art. We discovered a lively side of her that she had never known, which I at first thought was a good sign, though as her story unfolded it turned out to be a clue to her underlying bipolar disorder. When she was discharged from the hospital she was not allowed to return for outpatient art therapy, even though that is what she requested, but was required to attend a clinic near her home since she was on Medicaid.

A few months later I got a call from a nurse at WPIC telling me that Karen had made a serious suicide attempt but had failed because a sister rushed her to the hospital where the blood flow from the razor cuts on her wrists could be stanched. Even though she was in her teens, she couldn't be admitted to the Adolescent Unit where she knew the staff, but was sent instead to the Geriatric Unit, the only one that had a bed. I was called to come up there, and was shocked to see how regressed she was—almost catatonic.

I was asked to come to that unit to work with her, but for many visits I could only sit and talk softly, since Karen was mute. Finally, she began to respond not to my words but to some drawings I had made, so that our first communications were graphic ones. Although she was moving enough to draw and to look at me off and on, for the most part she remained locked in her rigid mental prison.

After trying many medications, which had no effect except to make her more groggy, the doctor in charge decided to try lithium. It worked miraculously and was the clue to the diagnosis of manic-depressive (bipolar) disorder. Ever so slowly, Karen emerged from the space in which she was trapped and began to talk as well as to draw, though I did not see the cheerful hypo-manic side I had glimpsed during her earlier hospitalization, only her sadness and paranoid suspiciousness.

Art was her salvation, allowing her to express feelings and fantasies that she could not put into words even when she was willing to speak, because they were so confusing. Eventually Karen was able to leave the unit for individual art therapy sessions in my office in the hospital **(A)**, and when she was finally released she was allowed to continue. I found it fascinating that during this period she was spontaneously making mandalas **(B)**, confirming the function of the circle as a holding space, an emblem of the wholeness for which she longed so intensely.

After I left the hospital to go into private practice, I continued to see Karen on a *pro bono* basis. I greatly admired her pluck, as she became the first member of her family to go on to college; first a community college and later the university, majoring in Child Development and Child Care. She was able to do the schoolwork with effort, though it was not always easy for her to concentrate. After more than the usual number of years, Karen proudly graduated and got a job in a Day Care Center.

Like many, she did not like taking her medication and would periodically go off it to prove to herself that nothing was wrong with her. Alas, that didn't work, and while she was not on medication her performance on the job and with people suffered. Her third psychotic break became obvious to me the day she visited me in my office. In fact, she was so disoriented and at risk that I took her over to the hospital and had her admitted against her will. She trusted me, but it was still painful for both of us.

Just as art and writing (especially poetry) had helped Karen, so writing helped *me* when I left on a plane trip the same night I had hospitalized her. I reflected on the terror of psychosis, and this is what I wrote as I flew across the country:

> Tragically, such a break is not only with the reality of the world outside; there is also a rupture within. And only time—and often drugs—can help the individual to

> reconnect with the personality which is the healthy self … the Self that lives and learns and loves with determination and vigor. I suppose we ought to be grateful that such ruptures with reality are now rarely permanent, that the world within and without can be regained, and that genuine living is possible for the majority of the time.
>
> Nevertheless, it still seems unfair, and it is my fervent wish that some day, when we understand much more than we do now of the biology and chemistry and electricity of that delicate thing called the mind, we will be able to eradicate these scourges of mankind forever. Although this may sound callous, it seems to me that an illness affecting the body is somehow less fearsome than one afflicting the mind, which distorts the only thing we have to orient ourselves within our constantly shifting universe.
>
> If the Self cannot be felt as a constant, through all the inevitable vicissitudes of existence, that seems to me to be the worst possible deprivation. For with a stable, ongoing sense of Self one can be centered, despite adversity and pain and loss. But to be disoriented, to be cut off from *who* we are—even more than where and when and how we are—must be an experience of such terror that 'nightmare' is a pallid way to speak of it.

After that experience Karen reluctantly decided that medication compliance was worth it, and she was able to forestall further psychotic breaks. But she was not able to maintain enough consistency in her behavior to keep a job, and finally ended up living on disability payments from Social Security, for which I helped her to apply. When I knew I was going to retire from practice, because of the strength of her attachment to me **(C)**, it was important to be sure that Karen was connected to a mental health center where her medication and living situation could be monitored regularly.

Both of us were disappointed that she was unable to accomplish so much that she had seemed close to, such as working with children or getting married. She had a wonderful spirit that I found quite inspiring, especially since her mother (who probably had an untreated mood/personality disorder) was so rejecting of her.

Karen was eventually able, despite her very meager income, to move out of her mother's house, to furnish her own apartment, and to find pleasure in her creative pursuits. Painting and making all sorts of things continued to be important to her, and when she would come into my office it was almost always with something she had created **(Figure 9.1)**—a photograph of her living space, her artwork **(D)**, and sometimes even the cats who were her steady companions.

Because she functioned at a high level when taking her medication, Karen tried and rejected outpatient art groups for those with chronic mental illness. Instead, she preferred to go the Pittsburgh Center for the Arts, where she took classes in art forms she had never explored before, thanks to their scholarship fund. One of the classes she loved was dance with an instructor named Phoebe, from whom I took tap after retirement and who remembered her well. Karen had always liked to dance, even though she had only a few years of ballet lessons as a child. One of her favorite self-soothing activities was to put a record on the phonograph and dance to it in her apartment. When the landlord complained, she had to turn down the volume, but she didn't stop.

Every year at Christmastime she would have a friend film her with a video camera doing a series of dances, for which she designed the set and costumes. She was very serious about this annual ritual, since it allowed her to give a copy of the video as a gift to each of the adults who had supported her in her struggle to stand upright. In addition to me, there was her grandmother and the only African American faculty member of the Child Development Department at that time, who had become a good friend.

Figure 9.1 One of Karen's self-portraits.

On the **DVD** you can see Karen doing one of her dances **(E)**. It is such a powerful testament to the human spirit, which though battered, remained unbowed. Even more impressive, although she was not able to hold a job, Karen volunteered whenever possible with elders and children with multiple disabilities at the School for the Blind. I am convinced that without her creative outlets, she would not have been able to do all that she did and to remain a solid citizen of her community as well. For Karen, the arts offered a lifeline on many levels and in many ways. To call them "therapy" seems almost too limiting, since they enabled and sustained both her spirit and her soul.

Children with Psychotic Disorders

My very first work as an art therapist was with a group of children who were diagnosed with *childhood schizophrenia*. Sometimes the professionals referred to them as suffering from *early infantile autism*. While they would probably be given different diagnostic labels today, most likely as having an *autistic spectrum disorder,* they would still be struggling with trying to stay afloat in a world that for them is more confusing than for children without problems in reality testing.

Art for many of them was, and still is, often as indispensable a language as it was for Aloise Korbaz, Adolf Wolffli, or my patient, Karen. I will first tell the story of Dorothy, whose art was her only intelligible speech, and who grew in remarkable ways from just seven months of weekly individual art therapy.

A Youngster with Childhood Schizophrenia: DOROTHY (10)

Many years ago I worked with Dorothy, a seriously disturbed, brain-damaged girl suffering from some loss of vision and hearing and from childhood schizophrenia. Adjunctive art therapy sessions were made available to Dorothy, as they were to all ten children on her residential treatment unit. She came every week from November through March and usually stayed for about one hour.

At first, her teacher having introduced me as an "art teacher," Dorothy wanted and expected some instruction in art. Rather quickly, however, she accepted the open-ended nature of the sessions, soon overcame her quiet reserve and initial disappointment, and began to relate in a warm and trusting way. Although she could speak, she did so rarely, since her speech was so distorted that it was very hard to understand. She was a most articulate draftsman, however, and from the first, was able to express her fantasies and ideas quite clearly through pencil and paintbrush **(DVD 9.3)**.

During her first three sessions, Dorothy concentrated on the drawing **(A)** and painting **(B)** of birds **(C)**, an animal she often pretended to *be*, making birdlike noises and flapping movements with her arms. She seemed "stuck" on a rather compulsive and careful way of doing this repetitive subject, always drawing the birds first in pencil **(D)**.

So, during the fourth session, after her attempt to paint a large bird with tempera led to frustration due to the lack of small brushes, I suggested that Dorothy try just using the paints without planning in advance. She did so, and became quite excited by her new freedom, literally dancing and yelping with glee as she let loose, slopping on one bright color after another, delighted even when they became muddy **(E)**.

When finished with her first such effort, she asked for the largest size of paper (18" x 24") and announced, with considerable excitement, "I'll make a monster!" She then did a rather fanciful and colorful painting of a multilimbed creature **(F)**, and followed this by saying, "I want to make another monster," this time drawing a birdlike creature saying "Growl!"

The following week, Dorothy began with one of her careful birds, an eagle, first drawn and then painted. She then drew at the right what she later called a "dummy," a crayon figure of a boy with strings like a marionette standing on a ladder, with his arm in the eagle's mouth **(G)**.

"I want to do another one!" she said, after naming the first "The Dummy and the Eagle." Her second drawing, in pencil, was an even more graphic picture of the destructive effects of the eagle's rage **(H)**. The figure, called both man and dummy, had a chewed-off arm, bandaged eyes, and had been violently injured. There was a narrator at the upper left saying, "Egles. Egles are mad. They want to kill man and eat them" (**Figure 9.2**).

Perhaps for the first time, the aggressive aspects of Dorothy's bird fantasy were clarified for those who worked with her, and maybe for Dorothy, too. The following week, emphasizing the flight aspects, she drew a saucy bird, then covered it over with dark paint, saying frequently, "Go home!" a commonly verbalized wish. A girl was then drawn in a cage (the hospital ward as she experienced it?) saying, "Boo hoo!" with a large monster-like creature at the right saying "Ha ha!"

This was followed by the drawing and painting of a large and a small bird, along with arm-flapping and repeated rhythmic chanting of the words "Go home! Go home! Go home!" Her final product in this emotion-filled session was a rather lovely, carefully painted, large and majestic bird **(I)**.

At her ninth session Dorothy shifted gears in her imagery, and began a long period of representing the children on the ward **(J)**, first in rows, later involved in typical activities **(K)**. Her perception of them was so accurate that it was possible for anyone who knew them to identify the figures **(L)**. These drawings were done mostly in marker, along with much verbalization about the children and her relationship to them.

This subject matter occupied her for the next six weeks, with increasing action and drama in the pictures. While she was always careful to include each of the others, she never drew herself. After what turned out to be the last one, I asked where *she* was, and with a grin she pointed to the bird flying overhead **(M)**.

Figure 9.2 Dorothy's angry eagle drawing.

At her fifteenth session, Dorothy again shifted symbols, carefully drawing a pictorial "list" of clothes, later identifying them as all belonging to the youngest child on the unit, a boy of five of whom she was jealous. She said she wished she had clothes as pretty as his, and complained that hers were so ugly.

The following week the clothes were drawn first, then a picture of an older boy and the younger one, in which the older one has thrown away the little one's doll and he is crying—perhaps her jealous wish as well as empathic fear **(N)**.

In the next session, she began her "cat phase," and for seven weeks made pictorial "catalogs" of cats **(O)**, pictures of cat families **(P)**, and of her fantasy wish of being dressed in a cat *costume* **(Q)**—a bit more realistic than actually *becoming* a bird **(R)**.

At her twenty-fourth session, the next to the last we were to have, Dorothy drew a picture of the young boy and many articles of his clothing, afterward circling those that she also possessed. She was talking much more by then, having improved considerably in intelligibility through intensive speech therapy, and had many questions about "endings."

At the last session, we reviewed the artwork in her folder, a useful way to help a patient to get closure during termination. She was very interested, studying the pictures quietly and closely, with little verbalization. The most potent pictures, those dealing openly with hostility, were passed over rapidly, and the greatest time was spent looking at those of the children on the ward.

She looked longingly at her portrait of the "Tortoise Shell Family," remarking that the mommy and daddy weren't there, though previously she had identified the larger ones as parents, and that the cats want to cuddle up to people (**Figure 9.3**). No doubt the perceived loss of parents was related to the impending loss of her art times and art therapist (**S**), to whom she had grown attached. She did one more drawing of clothing, an item or two belonging to each boy on the ward, then put her arms around me, saying, "I like you," and said a rather clingy goodbye.

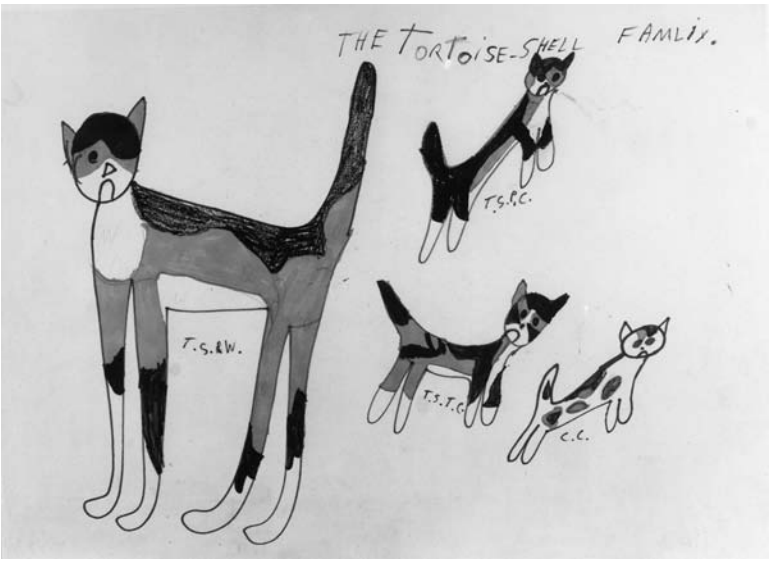

Figure 9.3 "The Tortoise Shell Family" by Dorothy.

Dorothy's therapy was ending prematurely, not because she was ready, but because I was pregnant, and in the early 1960s you couldn't teach or work in a child psychiatric unit for long after a pregnancy was visible. Although Dorothy was not able to express her anger at me then for leaving her, when I visited the craft class on the ward a month later, she showed me drawings of "Mrs. Rubin Having a Baby" **(T)** and "Mrs. Rubin being Attacked by Soldiers for Being Bad" **(U)**.

Twenty-five years later, despite having had considerable supervision and training in the interim, including a PhD in counseling psychology and completing the program in both adult and child psychoanalysis, I was confronted with a child in my private practice who proved to be even more of a challenge to work with than Dorothy.

Such children can often be helped through art therapy when other methods fail (Evans & Dubowsky, 2001; Rutten-Sarris, 2005). On the **DVD (9.4)**, you can see Marijke Rutten-Sarris, an art therapist from the Netherlands, working with two such children, using movement and mirroring as well as drawing. She calls her approach "Emerging Body Language (EBL) Therapy." I got to know Marijke when serving on her doctoral dissertation committee. As so often happens, I learned much more than I taught.

The little girl who was referred to me, however, would not let me get as close as the boys in the video of Rutten-Sarris's work. I am still not certain what would be the best diagnosis for my patient, though I suspect it would be what is now known as *autistic spectrum disorders*. Whatever her diagnostic label, and although Kitty functioned on a much higher level than Dorothy, she forced me to use all of my resources just to connect with her. Here is her story.

A Girl Who Spoke by Shutting Me Out: KITTY (4)

Kitty was a beautiful girl who had attended a progressive preschool for years but had no interest in other children. Instead, she would play out stories by herself and would sometimes do odd things, like flapping her hands or jumping up and down and twirling. At the

repeated urging of her teachers, her parents reluctantly brought her for treatment, choosing an art therapist because Kitty loved to draw **(DVD 9.5)**.

Her fluid and fluent drawings, which her mother gave me in abundance, reminded me of those by Nadia, a British girl with autism who had become famous for her remarkably detailed drawings (Selfe, 1977). Indeed, Kitty was a fine artist.

I felt concerned when I first saw Kitty's bizarre behaviors, fearing that she had *early infantile autism, pervasive developmental disorder,* or a *neurological impairment.* I soon referred her to a child psychologist for diagnostic testing, but Kitty was so oppositional that the findings were inconclusive.

At that point, I met with her parents again to try to get more of a developmental history, which would be especially important in trying to understand the nature of her difficulties. However, as had been true in our earlier meetings, their memories of Kitty's early years continued to be both inconsistent and vague. Since this was in the 1990s, I finally asked if they had videotaped her when she was little. They had, and were more than willing for me to look at their home videos.

The tapes were startling. While Kitty seemed like a pretty normal baby and toddler, her mother, the main videographer, was so intrusive that it stood out as the most significant feature. Mother's narration, which was constant while she was filming, as well as her boundary-less interaction with Kitty, introduced another possible motive for the child's puzzling symptoms and for her behavior with me, which had been evolving during the months I had seen her before viewing the videos.

In the beginning, Kitty had enacted her solitary dramas at a distance—as far away as she could get with her back to me in the large former living room of my office suite. After a few sessions, she began to use the smaller adjacent playroom (the former kitchen).

She would usually grab drawing paper and markers and quickly produce pictorial storybooks. She would tell me what to write on each page, but Kitty would not respond to any of my questions or comments. On the **DVD (9.5)**, you can see the cover and inside pages from one about "Wonder Woman" **(A)** and her adventures **(B)**, and another about being "In the Bubble" **(C)** and popping it to escape **(D)**.

Finally, she began to involve me in her dramas. Her favorite thing was to shut me out of the playroom space by literally shutting the door. Kitty would then gleefully control when and how she would *let me in*. Sometimes she would *shut me in,* being equally bossy about how and when she would *let me out*.

It was clear that she was trying to tell me something. But her message wasn't so easy to grasp. At first I thought she was telling me—by making me feel *left out*—that she was feeling excluded from the closeness between her younger brother and her mother, which I had observed and which was unusually intimate.

After viewing the videotapes of Kitty's early years, however, I realized that her primary need was to *create a boundary between us.* Her withdrawal from me and from other children was not simply an avoidance of people. It was also a way of *separating* from her loving but anxiously overinvolved mother, who was still having a very difficult time differentiating Kitty's needs from her own. She gave me permission to share my observations with her own therapist, who had referred Kitty to me.

The information contained in the videos helped her mother's therapist to help *her* to separate, thus giving Kitty the space she needed to grow more autonomously. As Kitty worked through her problems in therapy using both art and drama, she became more sociable at home and at preschool. Much to my surprise, when it was time to enroll in a kindergarten

she was even able to handle a public school (with good supports), which I could never have imagined when I first met her.

When I was getting ready to retire from clinical practice, I referred Kitty to a child psychiatrist. Her assessment was that the child was suffering from *Asperger's syndrome* at the high-functioning end of the autistic spectrum. Because Kitty was so distant and uncommunicative, I doubt that she would have been accessible to therapy at age 4 without the creative modalities of art and drama.

A Teenager With Asperger's Syndrome Uses Puppets: EMILY (16)

Many years after I saw Kitty, an adolescent I knew who had *Asperger's syndrome* was in the hospital for a bone marrow transplant because of her leukemia. Although she was already 16, Emily functioned in many ways like a younger child. I brought in art supplies as well as puppets, in my attempts to help Emily to express her feelings about what was happening to her, which she was unable to verbalize comfortably.

Although the art supplies held no interest for her, she was able to work through a good deal of the fear and rage she was experiencing by using the puppets, as did I in order to interact with her in a nonthreatening fashion. Emily began to request that I come more often, even though she had many loving visitors. It was clear that this adolescent needed the symbolic distance provided by the puppets to be able to cope with her terrifying illness and the effects of the treatment.

Four years later, after an almost miraculous recovery, I attended her graduation party from the special high school she had attended. Much to my surprise, the first question Emily asked me was whether I still had the puppets. She remembered the names she had given them, as well as many of the dramas she had created.

That experience with Emily reminded me of a paper written years earlier by a colleague about work with a retarded adult and how the symbolic function had been activated through art making (Wilson, in Ulman & Levy, 1981). Whatever the explanation, there is no question that individuals of all ages whose cognitive abilities are challenged in any fashion are often able to use the symbolic avenues of the arts more successfully than ordinary verbal language.

Living With Disabilities

Art therapy cannot give a retarded person comprehension, a blind person sight, or a person who is crippled mobility. But art can and does give those with disabilities a stimulating and pleasurable way to enjoy and to explore the sensory world. It gives them a way to be in charge in a limited sphere, to master tools and processes within their reach, and to savor the pleasure of skills honed through practice.

Art gives those with disabilities a way to "map out" a confusing sense of the body and the world. It gives them a way to define themselves through choices and decisions, and creations that are uniquely theirs. It gives them a way to create products of which they can be proud, which can add beauty to the world and meaning to their lives. Through art, a person can both escape symbolically, and come to grips with feelings—especially those about the disability itself, as Jimmy did in his Person and Self drawings (**DVD 6.7**).

While these benefits are available to all human beings, they have special value to the disabled, for whom—like the elderly—there are many more problems and many fewer avenues of expression. The same medical progress that extends more lives also saves more premature babies, who are at greater risk for having multiple disabilities.

Art gives people with disabilities a way to safely smear and pound, and to symbolically express feelings like anger—which is especially hard to do because they are necessarily so dependent on others. This was poignantly clear for Jane, a girl I met when I did a demonstration program at the Western Pennsylvania School for Blind Children in 1970.

A Therapeutic Art Program Helps a Partially Sighted Girl: JANE (11)

Jane was legally blind, although she had more useful vision than most of her schoolmates. Still, like them, she was angry about being blind, and resentful of the sighted adults on whom she was dependent. Jane didn't know the intensity of her retaliatory rage, but was able to express it symbolically in a story about her painting (**Figure 9.4**).

"This is a building which is a hospital, and in this hospital—there's just one patient in this hospital … The one patient is Mrs. Rubin … She had an accident. She bumped into another lady's car and … she punctured her eye." When asked what would happen, Jane said with a grin, "It's going to blind her!" She went on to explain how Mrs. Rubin would then be unable to work with children in art **(DVD 9.6)**.

When asked how she herself felt about it, she asserted with a sly smile, "I don't feel anything. My sight's coming back!" Having verbalized this wish, she went on to deny her disability completely, a fairly common phenomenon. "I can see just like a regular person!" In the course of group art therapy, Jane was eventually able to accept her disability—as well as her feelings about it—a necessary task for every blind individual.

Figure 9.4 Jane describes her painting.

Another child in Jane's group was more seriously disturbed. At first, because of the extent of his rocking and his chaotic behavior and self-talk, Larry was thought to be possibly psychotic. He came to the Child Guidance Center for 6 years of twice-weekly therapy while I consulted to the school and a blind social worker met with his parents. He used art and drama therapy to master repeated traumatic experiences, and to come to terms with the blindness caused by his congenital glaucoma.

Expressive Arts Therapy Helps a Blind Boy: LARRY (8)

Larry was an eight-year-old who had everybody worried about him. He looked and acted "crazy," and was always threatening to smash things or people. Sometimes he withdrew into a private world where he would sit in a closet and make up stories, playing all the characters using different voices. He was finally brought to a clinic for therapy, because the teachers and house parents at his residential school were unwilling to let him remain there without some kind of treatment. His parents reluctantly agreed to try the Pittsburgh Child Guidance Center **(DVD 9.7)**.

So Larry came to the clinic for weekly individual therapy, while his parents saw a (blind) social worker. Although it may seem strange that a boy with two artificial eyes was referred for art therapy, he enjoyed the sensory pleasure of squeaky markers and smooth wet clay **(A)**. At first, Larry made clay "rockets" in which he imagined himself as an astronaut, who would explore outer space **(B)**. The playroom was a safe "closet," where he could share his fantasies with an accepting adult (**Figure 9.5**).

Art materials often became props in his dramas, and these stories helped us to figure out why he was acting so "crazy" or—as he would say—"mental." Many of his early stories were about a boy getting lost, sometimes on a clay "planet." Then, for almost a year, he played and replayed scenes of doctor **(C)** /dentist (**D)** /nurse/patient. Though I was often assigned a role,

Figure 9.5 Larry and the art therapist.

sometimes he was both doctor and patient, doing things like examining himself or giving himself a shot, as on the **DVD (E).**

In fact, Larry had fifty operations for congenital glaucoma before his eyes had been removed at age five. To make matters worse, he had been jealous of his baby sister, and she had died of cystic fibrosis just before the operation. His repeated dramas were related not only to the trauma itself, but also to his unconscious guilt about his sister's death. He thought his blindness was a punishment for his badness.

With his dramatic flair, usually using art materials as props, Larry went on to create a series of dramas about a "Good Larry" and a "Bad Larry." He played both parts, and I was myself/parent/teacher according to his instructions **(F)**.

The struggle went on for many months, and included both repeated injuries and symbolic replacements for his lost eyes **(G)**, but finally the "Good Larry" was victorious. He ended up taming the "Bad Larry" so that he could stay at the School for the Blind, where the *real* Larry was starting to make friends and to enjoy learning. He left after six years of therapy, announcing his "resignation" from the Child Guidance Center. He had come out of his closet of fantasy and was warmly regarded by others.

Fifteen years after he terminated, I ran into Larry on the street. He recognized my voice immediately, and greeted me warmly. He told me proudly about the life he had made for himself: his friends, his job at the Guild for the Blind, and his performances at a local Comedy Club. The latter was no surprise, since he had always done wonderful vocal imitations and musical improvisations **(H)**. He recalled our times together fondly and grinned as he announced that he was no longer "mental!"

Probably ten years after that meeting, I got a phone call from Larry, telling me sadly that his mother **(I)**—his best friend in the world—had died and asking if he could come in to meet with me. Even though I had by then retired I agreed, because he sounded so forlorn.

He had two requests: for a copy of the film I had made about the art program at his school, which he remembered remarkably well, and for some of the tape recordings from our sessions **(J)**. We had used the microphone of the tape recorder extensively so that he could replay what had gone on in his many dramas. Months after that, he called to say that he had copied all of the tapes, and wanted to meet again to return the originals.

Larry's struggle to stay sane in a very confusing world was one of the more dramatic in my own early years as a psychotherapist. It was moving that he remembered the details of our work so well **(K)** and that the sound recordings of the sessions and on the film sound track were so meaningful and comforting to him. Art can also function as such a *transitional object,* allowing separation to happen more comfortably.

History of Art Therapy for Those With Disabilities (**DVD 9.8**)

When I began working with Larry in 1969, blind adults were making brooms, not expressing themselves creatively. Like the elderly, individuals with disabilities were most often seen as incapable of genuinely creative work. In 1967, when I started an art program (**Figure 9.6)** at the *Home for Crippled Children* **(A)** (now the Children's Institute), I found only one project, reported in the News section of the *Bulletin of Art Therapy* in 1964 (p. 66), which promoted authentic work with those with disabilities.

A New York artist had started a program in 1958 with cerebral palsied adults. He had noticed something I also observed, which looked miraculous—that when a person with involuntary muscle spasms is absorbed in a painting process, like mixing colors, he often achieves a degree of relaxation that allows him to actually control the brush!

Figure 9.6 Art therapy, Home for Crippled Children.

In the spirit of the early pioneers—Viktor Lowenfeld **(B)** (1952, 1957) and Henry Schaeffer-Simmern (1961)—there had been a number of individual art teachers who had faith in the creativity of those with disabilities, and who tried to dispel negative stereotypes in their books (Clements & Clements, 1984; Lindsay, 1972; Fukurai, 1974; Gaitskell, 1953; Lisenco, 1971).

Although promoting genuine creativity was rare, there were notable exceptions. One was *Creative Growth*, a sheltered workshop developed by an art teacher and a psychologist (Katz & Katz, 1977, 1990). This environment—in which each person's creativity was carefully nurtured—was a model of respect **(C)**. In such an atmosphere, individual talent could blossom, like that of artist Dwight Mackintosh **(D)** in *The Boy That Time Forgot* (MacGregor, 1992), and fiber artist Judith Scott **(E)** (MacGregor, 1999).

In 1967, Sally Smith (1979) founded a school for dyslexic children that took advantage of the learning potential in the arts through an arts-centered curriculum. Like Creative Growth, the Lab School **(F)** is still going strong. Both can be seen on the **DVD (9.8)**. In addition, the Waldorf Schools have long stressed the therapeutic benefits of art for mentally retarded individuals of all ages (Kirchner, 1977).

Gradually, art therapists began to enter the schools, teaching and helping children with disabilities. In 1977, Virginia Minar (**Figure 9.7) (G)** reported on a 3-year pilot study of art therapy with special education students in the schools of West Allis, Wisconsin (AATA *Conference Proceedings*). Since 1979, the Dade County, Florida schools have had a large art therapy program founded by Janet Bush (**Figure 9.8) (H)** and still serve many children, both individually and in groups (Bush, 1997).

Lowenfeld's goal (1952, 1957) was to help children adjust to the emotional or "subjective handicap" caused by having an "objective handicap." Anderson (1992, 1994) emphasized the need for the art-giver to *adapt* whatever is offered to the abilities of a disabled child **(I)**. Silver's demonstration project with deaf children in 1967 **(J)** led to traveling museum exhibits (Silver, 1978), and a curriculum based on her ideas was developed for youngsters with cognitive difficulties (Fugaro, 1985). A recent compilation describes art therapy with deaf people of all ages (Horovitz, 2007).

Figure 9.7 Virginia Minar, art therapist.

Figure 9.8 Janet Bush, school art therapy.

Donald Uhlin **(K)** had become disabled after contracting polio as an adult (**Figure 9.9**). Having studied art education with Lowenfeld, he then turned to art therapy (Uhlin, 1972). Edith Kramer's **(L)** work with blind children inspired many of her ideas about art therapy (Kramer, 1971, 2000). Her student, David Henley **(M)**, has also made important contributions in his work with children suffering from a variety of disabilities (Henley, 1992, 2002). Finally, Frances Anderson (1992, 1994) has had a major impact on this area through what she called an adaptive approach (**Figure 9.10**).

As with the elderly, there are still misconceptions about art with this group. But the tide has been turning, due partly to a landmark piece of legislation: PL 94-142, the Education of All Handicapped Children Act of 1975—updated in 1990 as the Individuals with Disabilities Education Act, IDEA-PL 101-476. Public schools are now required to deliver the best possible education to all students with disabilities. Moreover, successful lobbying enabled *art therapy* to be mentioned as a *related service*.

Figure 9.9 Donald Uhlin, developmental art therapy.

Figure 9.10 Frances Anderson, adaptive art therapy.

The year 1975 also saw the birth of the National Committee*Arts for the Handicapped (NCAH), later Very Special Arts, now VSA Arts. The organization has supported Very Special Arts Festivals **(N)** and model programs in every state involving artists, educators, and therapists. It has also funded studies, publications, and conferences such as "Art in the Lives of Persons with Special Needs" sponsored by the National Art Education Association and the American Art Therapy Association in 1979. Since art for those with disabilities was beginning to be offered more widely, territory and roles needed to be defined.

The Family of the Disabled Individual

The 1974 Conference on Arts for the Mentally Retarded, which gave birth to NCAH, was funded by the Joseph P. Kennedy Jr., Foundation. The Kennedys were energized by their distress over the tragic life of their sister Rosemary, who was institutionalized after a lobotomy rendered her profoundly, rather than mildly, retarded. Sally Smith's failed efforts to educate her learning-disabled son led her to start the Lab School. And those who provided the force behind PL 94-142 were frustrated parents. The grief and confusion of the family are inevitable, because a disability affects everybody. And the others need as much help in coming to terms with their lot as the individual who has the disability.

Thus, a *family art evaluation* enabled the older brother of a multiply handicapped blind child to express his rage in his family representation, in which his wood scrap shape was shown shooting missiles at the shapes of all of the others **(O)**. For the first time, this teenager was able to represent and then to talk about how displaced he felt by his parents' constant involvement with his sister's overwhelming needs.

In a *mother–child art group* at the school for the blind, Larry's mom asked him to *paint* with her, only afterward realizing how impossible it was for a boy with artificial eyes to meaningfully use this medium **(P)**. She was then able to discuss with the other mothers her denial of his blindness, which made it hard for Larry to give up his own wishful fantasy that he was "the only kid at the blind school who could see."

In addition to joining with their children on occasion, the *mothers' groups* at the school for the blind sometimes used art activities as a way to explore their own feelings and fantasies about their visually impaired children. Several motivated mothers went on to run *support groups* for other mothers, with training in the use of art to facilitate groups. Riley also (1994) conducted *multifamily group art therapy* with families who had a disabled member.

Parents and siblings of disabled individuals suffer greatly from their own confused feelings, like guilt over their role in causing the handicap, or shame about feeling resentment or envy. A group of mothers of disabled children was formed at their request, after accidentally meeting in my waiting room. They met for many years after their children's therapy had ended, supporting each other in their lifelong struggles.

Whether a disability is temporary, permanent, or unpredictable, it affects a person's self-concept, mood, and outlook on life. Although the disabled individual may not be in treatment specifically for emotional problems, art can become a powerful tool for understanding, for self-expression, and sometimes even for healing itself. A drama therapist and I once helped a group of teenagers born with cleft palates to make a film. The movie **(Q)** was designed to tell their families and friends what it feels like to have such a painfully visible condition—a most creative way to cope.

Problems Especially Helped by Art Therapy (DVD 9.9)

I have not written in detail about each of the many conditions that can be treated through art therapy, for that would be not only lengthy, but also beyond my expertise.

Although art therapists see people of all ages, with every kind of psychiatric problem and every type of disability, most are not singled out below. Since art therapy seems to be uniquely helpful for certain disorders, however, I have chosen to highlight just a few of them as examples of the much larger group of people we serve.

Eating Disorders

Art and other expressive therapies are very effective in the treatment of *anorexia, bulimia,* and *compulsive overeating.* People who are obsessed with their weight, who frantically pursue "magical control of the body" (Levens, 1995), are usually not in touch with the powerful feelings and fantasies they are working so desperately to master. Because what is repressed can be expressed in imagery more easily than in words, art therapy is a way to get in touch with the ideas behind their symptoms. And using art materials can also satisfy the intense need of these patients to be in control (Dokter, 1994; Hinz, 2006; Hornyak & Baker, 1989; Makin, 2000).

Since those with eating disorders tend to deal with their problems through action, the energy involved in creating makes art congenial (Hornyak & Baker, 1989). For these patients, who are indeed "starving" for affection, art therapy offers a way to be "fed," by "gobbling up" luscious supplies—and a way to "feed" the self and others, by "cooking up" delicious creations. It is thus not surprising that the first hospital to specialize in treating eating disorders—the Renfrew Center—has made extensive use of art and other creative therapies **(A)**. For Lila, in the vignette below, art therapy was her self-selected treatment of choice.

Art Therapy for an Adolescent with Anorexia: LILA (17)

I had met Lila during her junior year of high school when she was hospitalized for a life-threatening weight loss. She was referred because of her artistic talent, as well as her tendency to hide feelings in defenses like intellectualization and rationalization. She attended an art therapy group I led on the adolescent unit, but she preferred her individual sessions. After Lila was discharged and I had left the hospital for private practice, she asked to continue in art therapy. We met twice a week for about a year.

Like many patients with eating disorders, Lila had found that her old symptoms began to return as soon as she left the controlled environment of the hospital. Unlike some, however, she was eager to overcome them. She expressed her feeling of emptiness and her longing for nurturance in a series of agonized and eloquent drawings **(B)** and paintings **(C)**. Despite Lila's excellent intellect, she could articulate her pain in pictures far better than in words (**Figure 9.11**). Using her own images **(D)** as springboards for associations, she began to name her vague feelings **(E)**. An intense family art evaluation also enabled both of us to better grasp the source of her problems, as they related to her painfully enmeshed **(Figure 9.12)** family **(F)**.

Meanwhile, determined to increase her appetite and to maintain a normal weight, Lila got an after-school job in a homemade ice cream parlor. During her senior year, she also concentrated on building her portfolio, and was able to win a full scholarship to a prestigious art school in New York. She was then able to manage college without a recurrence of her disabling symptoms, a significant achievement.

Shortly after she had graduated, Lila called from New York to tell me that she liked her design job, and that she was enjoying a deeply satisfying love relationship. Ten years later, I heard indirectly that she was still finding constructive ways to nourish herself and had been able to maintain a healthy distance from her family while sustaining warm connections with friends and relatives.

Substance Abuse

Some patients with eating disorders also suffer from the similarly oral and addictive problem of *substance abuse*. Since Elinor Ulman's pioneering work at the Alcohol

Figure 9.11 One of Lila's body drawings.

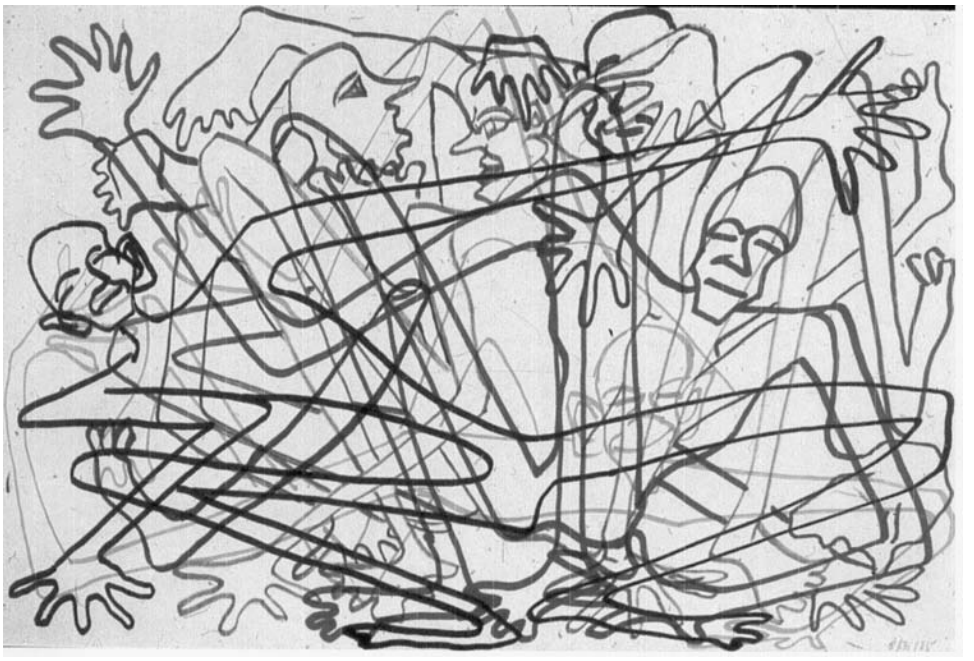

Figure 9.12 Lila's enmeshed family drawing.

Rehabilitation Unit of DC General Hospital in 1951, art therapy has been used extensively with such patients. It seems to be appealing for many reasons, such as the fact that it is both concrete and gratifying. Many forms of art therapy have been used in the effort to help addicts—from individual, to family, to group, to the multifamily group art therapy employed with mothers and children in a recovery program (Chickerneo, 1993; Linesch, 1993; Waller & Mahony, 1999).

The women I saw in one drug rehabilitation program were initially distrustful and wary, skeptical that group art therapy could really help. Like children, they delighted in being "fed" beautiful materials, "hungrily" but constructively using them to create personal statements. They were surprised at their own creativity and enhanced self-esteem. You can hear some of their comments on the **DVD (G)**.

Art Therapy Helps a Recovering Addict: AMELIA (25)

Amelia, for example, created a series of pictures, paintings, and sculptures of graceful *swans*. She spoke to the group with feeling about how she had discovered that she herself was not an *ugly duckling* after all, but rather a *swan*—and that her little swans had grown as she had grown. You can hear and see her, as well as her artwork, on the **DVD (H)**. She planned to study art after finishing the treatment program.

Survivors of Sexual Abuse

Whether the abuse happens in childhood or adulthood, it is often repressed and inaccessible to both patient and therapist. Even if the memory is available, the victim has usually been threatened with reprisal if they tell anyone what happened. So whether the traumatic events are unconscious or suppressed out of fear, art is an excellent avenue for "telling without talking" (Cohen & Cox, 1995).

Art offers a way for a person of any age to utter "silent screams and hidden cries" (Wohl & Kaufman, 1985). As society becomes more comfortable with the truth, art therapists are helping more people of all ages in an ever-expanding array of settings, from shelters to hospitals.

It makes sense that art is helpful in accessing images that torment the mind **(I)** (Arrington, 2007; Brooke, 1997; Hagood, 2000; Klorer, 2000; Malchiodi, 1997; Murphy, 2001; Spencer, 1997; Spring, 1993, 2001; Tinnin & Gantt, 2000). It also makes sense that all of the arts are helpful in working with wounds buried in the body as well (Brooke, 2007; Carey, 2005; Gerity, 1999; Gil, 2006a, 2006b; Malchiodi, 2008; Simonds, 1994) **(J)**.

Pioneer Clara Jo Stember literally carried art therapy to abused children in her *Artmobile* in the 1970s, and art therapist Connie Naitove contributed a chapter to the *Handbook of Clinical Intervention in Child Sexual Abuse* (Sgroi, 1980). Since abuse is usually perpetrated by a family member, the art therapy often involves the *family* (Landgarten, 1987), as well as *groups* of mothers of abused children (Landgarten & Lubbers, 1991) or of mothers *and* children (Linesch, 1993).

Frances Anderson led two ceramics groups for incest survivors, which she documented in a film, *Courage! Together We Heal* **(K)** (Anderson, 1991). By the time adult survivors of abuse seek treatment, they usually have problems in many areas, and often carry multiple psychiatric diagnoses. They sometimes discover repressed memories of sexual abuse in the course of therapy, which has stimulated serious questions about the accuracy of such "memories."

Despite many years of intensive psychotherapy, Alice Miller, a well-known analyst and author, did not uncover her own abuse until she started painting the images she published in *Pictures of a Childhood* (Miller, 1986). Similarly, a successful artist didn't find her buried images of trauma until she was drawing the pictures in her book, *A Child's Story* (Harris, 1993).

Dissociative Identity Disorder (Multiple Personality Disorder)

Closely related to being a survivor of abuse is the defensive development of *dissociative identity disorder (DID).* Art is often the preferred language of some of the *alters*—split-off parts of the self that "went away" while the abuse was occurring as a way of defending against an intolerable trauma, as in *Sybil* (Schreiber, 1974) and *The Three Faces of Eve* (Sizemore, 1977; Thigpen & Cleckley, 1957).

Readers and viewers of *Sybil* (Schreiber, 1974) may recall the drawings by her alters of different ages and personalities. *Christine Sizemore* (1977), whose story was told in the film *The Three Faces of Eve*, spoke at the 1980 AATA Conference (*Proceedings)* about how helpful her own painting had been to her. Several have written about the treatment of dissociative identity disorder through art therapy (Cohen & Cox, 1995; Cohen & Giller, 1991; Gerity, 1999; Kluft, 1993; Spring, 2001; Virshup, 1993).

Formerly known as *multiple personality disorder (MPD),* this painful condition is caused by severe early trauma, usually some kind of sexual, physical, and/or psychological abuse. At the Intensive Trauma Therapy Institute in Morgantown, West Virginia, art therapist Linda Gantt and psychiatrist Louis Tinnin have developed an innovative method for treating patients with this disorder. An excerpt from a session is on the **DVD (L)**.

From Depression to Dissociation: The Story of ELAINE (40)

A Life of Sadness and the Search for Solace When I first met Elaine she was in her mid-forties and couldn't remember ever being happy **(DVD 9.10)**. In a family drawing done at age 4½ she looks really sad in contrast to her sister and parents **(A)**. Indeed, she had been deeply depressed, having first sought treatment as soon as she got away from her controlling mother while feeling suicidal in college. From that time on, she had seen a therapist for most of her adult life.

At first it seemed that her problem was major depression along with compulsive overeating, but as she recalled more and more of the abuse she had repressed, she began to cut herself compulsively, and it eventually became clear that she suffered from a dissociative identity disorder. We worked together for a number of years, and there is no question that I learned as much from her as she felt she was helped by me and art therapy.

The following autobiographical statement was written at a point when she was feeling excited about what she was learning in art therapy.

Elaine's Art & Therapy Autobiography (**DVD 9.10**) Art seems to me to be a wonderful and a scary process all mixed together in a way that can be freeing and rather astonishing. I came to art in a different way. I had been raised in a family where being able to draw and paint was taken for granted—at least by the adults. Both of my grandparents painted—my grandfather in oils and my grandmother painted delicate patterns and flowers on china. My mother also painted in oils, used pastels, and did cartooning. My sister too seemed to be accomplished with pen and ink drawing. I, on the other hand, was convinced that I was unable to draw or paint since what I wanted to do NEVER matched what I was able to accomplish.

Curiosity was further hindered by a mom who, as I grew older, did all of my art assignments for me. The only area she was not able to "mess with" was clay since that HAD to be done at school, because the clay couldn't be brought home and we didn't have the materials at home. My seventh grade art folder, which was supposed to be decorated and designed by myself, was done by my mom with much more beautiful results than I could ever have

produced. It wasn't mine but the teacher accepted it, even though it was very obvious by my class work that this could not have been my work. I never attempted any more art classes in or out of school.

[Years later,] I volunteered to do the Arts and Crafts for a one-week learning disabilities camp. I wanted these kids to have great projects and to be successful if I had to kill myself to do it. And the project that has stuck with me over all these years was the one where I gave each child a lump of Mexican pottery clay and said "make what you would like." Because I knew the kids, I could see themselves in each thing they made. The clay was so good for them and they had such fun. I even kept some of the pieces I had been given as reminders of some of the kids. They had put themselves into their work.

You are probably wondering where *art therapy* comes into this saga. While I was teaching preschool and learning to use finger paint with the children, I was in therapy for depression using mainly words. One evening, I could stand the anger I felt no longer and got out paint and canvas and put my feelings on canvas. When I was finished, I felt better, but the painting made me feel uneasy. It was so strong and obviously furious that I didn't want to acknowledge that all that was inside of me. However, I obediently took it with me to my next therapy session where I was made to sit looking at it during the whole session.

I didn't want it in my apartment so I left it with my therapist. That painting appeared at each session for months—right in front of my chair where it was pretty hard to avoid looking at. I HATED IT. Looking at it each time did not help to "get at" the anger. As a matter of fact, I think it helped to push it further down. The therapist finally got the message when I kept closing my eyes and turning away so that I couldn't see it. When he left the clinic, he returned the painting to me. I took it home and hid it behind a dresser for the next two years.

Two years later, I brought it out to show my new therapist how explosive and out of control the thought of anger was to me… . How I was convinced that anger was ugly, that it was harmful, scary, terrifying, and I was sure I was sitting on a time bomb of this type of anger as expressed in the painting. I made my point. I again left the painting, but this therapist had the kindness and sensitivity to not haul it out every session and make me look at it.

In my therapy, however, I had hit a roadblock. I had some very horrifying feelings attached to some events in my life that I was not able to tell. I knew what I wanted to say, even what I needed to say. I trusted my therapist, but I couldn't make myself say the words. He suggested that I get some finger paint and try painting what it was I wanted to say. He said that finger paint would allow me to move quickly if I needed to. If the images were too scary, I could always wipe them away.

It was a frightening thought and I at first rejected it. I went out to eat and later found myself in a toy store buying the paint and paper. I left everything in a box in the living room and went to bed. I couldn't sleep and got up at about midnight. I set up all that I needed. I promised myself that I would not wipe anything out, and I would not censor anything that came up. I painted feverishly for about an hour. When I was done, the living room rug was covered with pictures detailing what I remembered from early childhood … the very scenes and events that I had been unable to put into words **(B)**.

I took them in the next session. I couldn't look at him but I slowly and haltingly described what was in each of the pictures **(C)**. At the end of the time, I was still scared but I felt better. As if a great secret had finally been revealed. I was gently told that I had been sexually abused as a child, and that the scenes I had remembered and painted showed this.

We also talked about the experience of using art and what it had meant for me. I had found it hard to do—to begin. But I had also found a way to show people what I didn't have

the courage to put into words. This therapist recommended that I consider *art therapy* as a way through the words, to help me deal with pre-verbal information and to help with the material that had just been brought to light. [At this point her male psychotherapist referred her to me for adjunctive art therapy.] I began, stronger and interested in this process but still carrying the residue of all my previous experiences with art. I chose clay—the only media that seemed MINE. I painted at home, but still used modeling paste and thick paint to almost sculpt the paintings **(D)**.

Clay was wonderful! It was very forgiving—I could start over. It took energy to manipulate and that helped reduce my tension and anxiety. Whatever I made, I made so it faced me—it was mine, and even though my art therapist was watching as I worked, I didn't need to reveal it until I was ready. It was solid and had dimension—something I had great difficulty managing in painting. I could work quickly with the urgency that the feelings seemed to demand and still have something done at the end of the time. Judy has often wondered why I am so adamant about only using brown clay.

I have said that I like the texture better, like the color better, that gray is too sticky—but it wasn't until I began to write all this, that I had an inkling that maybe it's because my first good experience as a teacher with art came with the brown clay I used with the kids at camp. It makes me feel good. The brown clay also seems more life giving than the gray, which seems to be spooky and dead.

I have used other media—watercolor, pastels, chalk, and acrylic paints **(E)**, but I still prefer clay. It seems funny to me that I can be working and suddenly "see" something in the clay that can be formed and worked to produce an expression of what is going on in my head at the time **(F)**. I prefer to just let it happen rather than being given an assignment. It seems more "mine" than trying to make something come through a demand. It's funny too that when I paint [at home], it is usually at a time of either great stress **(G)**, or a time of success **(H)**. Believe me, stress has won out over success more times than I care to think.

It's just like the clay in many ways. I get a fragment of an idea or thought and begin to think about the materials or ways I can show it. Sometimes I know just what needs to be done. I have wandered up and down the aisles of craft and art supply stores until something clicked and I identified the material I needed to complete the image. I don't see a picture—I describe it in words to myself—but I know what I want it to look like **(I)**.

How is all this different from "talk therapy"? I think it's the best of both worlds. It's another way to help yourself express things clearly for yourself and also a better way to express yourself with the help of a therapist. Sometimes words are not enough. Sometimes showing is needed as well as telling. Sometimes the words we use have different meanings and emotional attachments for others than for ourselves.

There is one additional special advantage I can see—change and progress become visible over time for both client and therapist. You have a record of what you have "worked on" and how you have changed by looking at the artwork. It is very comforting to see progress rather than being told that you have progressed. Words are so slippery and hard to capture—art is real and tangible.

For me there was the added benefit of becoming more confident about expressing myself and showing my feeling to another as I got more involved in art therapy. When you have come from the "do it the right way" school and are encouraged to be free, it spills over into other areas of your life …

Am I glad about this experience? YES. But I'm also realistic enough to know that most people's experiences with art through school can have a great impact on whether they approach this with anticipation or dread. I think of the people that I met in the hospital

during the art therapy groups there. Most of them were terrified, felt incompetent, and afraid of showing the group what art idiots they really were. They had been brainwashed by their past experiences into thinking that art is only done by artists and they can't possibly do this stuff. As time went on things got a little better, but I'm not sure that any but a few would have actively chosen art. I think this is terribly sad.

Do I choose art all the time? Not any more. Sometimes I know I need to work with the clay, and other times it is OK to just talk. I have become more flexible about what material I use in the therapy room, but BROWN CLAY IS STILL MY FIRST CHOICE.

Elaine's Course of Treatment What Elaine didn't write about, but what was most vivid for me in our work together, were the changes in her state of consciousness while creating. After she was comfortable with me, she would start to work with the clay and would seem to disengage, with no talking or looking—just intense absorption in the process. Her modeling process seemed to have a life of its own, as she would first manipulate, find an image in the clay, and develop it. Then I would ask her to tell me about it, and to say what came to mind while looking at it **(J)**.

She had also taken to painting or sculpting more at home, most often when dealing with immense stress and, though rarely, intense joy—in response, in other words, to unbearable inner pressure. Although she had always thought she would need to see me forever, she was able to "take a break" for a whole summer, about which she was greatly relieved. She left her sculptures and paintings behind, perhaps to "hold her place" while she experimented with independence from me.

For most of Elaine's therapy, clay was her chosen vehicle of expression, as she struggled to work through her wordless scream of pain. She not only created art during her therapy sessions, but also at home—especially at times of deep distress. One of her paintings was a vivid statement of how imprisoned she felt by her psychic pain and persistent depression, which had led to a brief voluntary hospitalization because she was feeling suicidal and afraid of acting on it **(K)**. In the painting, a puffy, sad grey face looks out from behind black bars of raised paint. It is an eloquent image of helplessness.

For Elaine, art therapy became a way of finding out what was inside, in a place that felt increasingly secure over time. She called it a "holding environment," and gave that title to one of her sculptures **(L)**. In it, a person (Elaine) holding an infant (her small victimized self), leans against a well-rooted tree, her favorite symbol for support (**Figure 9.13**).

Within a month of starting art therapy, Elaine had reduced her verbal therapy sessions to once a week. Even though she liked and trusted both therapists, she requested that we not talk to each other, but that *she* be the one to communicate with each of us. After a year of working on parallel tracks, Elaine decided that she was ready to share her artwork and space with her talk therapist.

This session was immensely powerful, as she showed him her sculptures and paintings on display (**M**). Since her divorced parents had never been able either to deal with her together, or with each other, the joint meeting resonated on many levels. We agreed to have such sessions whenever Elaine wanted. When her male therapist moved to another city, art therapy became the primary treatment, twice a week.

Several years later, Elaine decided to join a survivors group at a local agency. As she began to trust and learn from the group therapist, a nun, she wanted that woman as well to know and to see her continuing search for healing through art. She, too, visited my office while Elaine, by then better able to talk about her creative experiences and the images she had made, gave her a guided tour.

Figure 9.13 "Holding Environment" by Elaine.

A few months later, after some frightening experiences with compulsive self-injury (cutting), Elaine discovered that the trancelike states in which she often modeled the clay were a repetition of the dissociation with which she had defended against early abuse. Like others, she had developed *alters*, multiple personalities related to the age and nature of the abuse, who began slowly to emerge, sometimes while she was creating art.

There is no question that art therapy allowed her to get to know and to express aspects of her history and disown parts of her self, which she might not have found out about as soon, or in as comfortable a fashion. Art therapist Patti Prugh, who has worked with patients with dissociative identity disorder for many years at Sheppard Pratt Hospital, feels that art allows disparate parts of the self to collaborate more comfortably than they can through words.[1]

After many years of work and many images (**N**) of rebirth (**O**) and of the therapeutic situation (**P**), it was naturally difficult for Elaine to say goodbye to me and the safe space of the art therapy room (**Q**). We were ending, not because she wanted to as when she had taken a break for a summer, but because I was retiring. Even though the grown-up Elaine (host personality) was understanding, and had made a good attachment to a nurse-therapist who monitored her medication at her local clinic during a long transition period, her child-parts were frightened and angry. One of the ways in which art helped her to separate as a "transitional object" (Winnicott, 1971a) was that she was able to take most of it home as well as to leave a good deal of it with me.

In her very last art therapy session, Elaine made a sculpture that reminded me of the one she had done four years earlier (**L**). The tree had not been in her work for a while, perhaps because she felt more grounded herself. In its place was a hand, cradling a person who is holding a baby (**R**). Although she traced the title—"Therapy"—into the wet clay, she called later asking me to smooth it out, feeling that the sculpture alone said it as well if not better (**Figure 9.14**).

I find it an eloquent statement about the nature of therapy through art, where the provision of a *holding environment* (Winnicott, 1971b) allows a person to go deep inside, to see what has been buried out of fear, to get to know and accept it, and to then be able to "go on being" (ibid.). Making art allows the feared idea or impulse to be literally "seen" and the

Figure 9.14 "Therapy" by Elaine.

creator to be in charge, instead of being at the mercy of internal pain, which requires too much of the self to be spent in defense at the expense of living.

Is Art Therapy Dangerous for Some People?

This question is often asked by other professionals who worry that art therapy may put their patients at risk. The fear is that people whose controls or reality testing are already weak might be overstimulated by the materials or overwhelmed by what emerges and go "over the edge" mentally or behaviorally. This anxiety is shared by some art therapists, who issue such warnings as: "Never use red paint with psychotic patients" or "Avoid clay with children who have conduct disorders."

Certainly, if profoundly retarded children put art materials in their mouths, then it is best to finger paint with chocolate pudding or to model with edible dough. Or, if patients are agitated and potentially violent, it is common sense not to provide dangerous tools like scissors. And of course one must set limits on destructive uses of materials, like throwing clay at other people or pouring paint on the floor. Nevertheless, art therapy is especially useful in treating individuals of all ages who have difficulty managing their anger (Liebmann, 2008).

Yet it has been my experience over the last 45 years, in my own work—and that of the many therapists I have supervised in the use of art with a wide range of patients—that there is no one for whom art therapy is necessarily hazardous, although it is naturally more helpful to some than to others. I believe that whatever dangers may exist are due not to problems inherent in art, but to inadequately prepared clinicians.

That is why art therapists in training are required to have many hours of closely supervised experience, in order to be able to utilize themselves and their modality safely as well as creatively. In my experience, when patients are given a choice of materials and themes, even those who are acutely disturbed tend to select media and ideas they can handle. There may be more of a risk when the art therapist decides what is *best* for a patient or group and that assignment turns out to be unmanageable.

Nevertheless, if an art therapist is imaginative and knows a broad repertoire of possibilities, and if she can provide structure and help when needed, most patients can be enabled to have a safe and satisfying art experience most of the time. A good clinician knows when it is best to modify or modulate the art experience, so that it is not frightening for the patient. In other words, if the art therapist is skilled, potentially disruptive art experiences are less likely to occur. And if they do, it is usually possible to transform them into events that are not traumatic.

Concluding Thoughts

As Viktor Lowenfeld said so eloquently in the quotation that began this chapter, art therapists know that "every human being is endowed with a creative spirit." That conviction, along with a belief in the power of art—to liberate, to enliven, and to heal—fuels the effort to reach people of all ages with all kinds of psychological and physical problems. With the energy born of this faith, art therapists have been able to fan the creative spark inside many who had given up. From the very young to the very old, from those who are mute to those whose words camouflage feelings, from those who live in mental pain to those who seek self-development, art therapy can help artists and non-artists alike. Although it is a poor recording, Lowenfeld's words shine with the passion of his conviction that all human beings have the capacity and the right to create **(DVD 9.9M)**.

Many different approaches to assessment and treatment are used in art therapy, and there is no single agreed-upon method for work with any particular group. What is clear from reading the literature is that art therapists take responsibility for learning about the special needs of the particular people they are trying to help. Whether patients are psychotic, neurotic, or have learning disabilities, art therapists attempt to fully understand their problems in order to help them with art in a safe and sensitive way.

Since there is such a wide range of people who can be served, art therapists can sometimes choose to work with those with whom they are most comfortable. The practice of art therapy with different groups of people naturally varies considerably. Doing art therapy with an autistic four-year-old, for example, is radically different from helping rebellious adolescents, paranoid adults, or withdrawn elders. In order to be most effective, art therapists get to know the group in general as well as the individuals—who are always unique.

In a similar fashion, the role of the art therapist in diverse settings varies considerably. In order to be most effective, art therapists learn about the institution they work in. Whether its mission is psychiatric, rehabilitative, or educational, an art therapist learns about the type of place as well as the particular hospital, clinic, or special school in which she finds herself. The next chapter will deal with the widening range of places, the people within them, and the ever-expanding purposes being served in the developing world of art therapy.

Endnote

1. Personal communication, April 17, 2008.

CHAPTER 10
Places We Practice

Art is man's most passionate rebellion against his fate.

André Malraux

A slogan to live by … Out of the hospitals and into the world!

Bernard I. Levy

Introduction

An analyst once wrote: "Man creates, as it were, out of his mortal wounds" (Meerloo, 1968). Most of the situations in this chapter concern problems that are not primarily psychiatric. Instead, they have to do with stressful things that can happen to ordinary people—like illness, bereavement, violence, dislocation, or discrimination. In order to be available to those who are facing crises of all sorts, art therapy has migrated from the mental hospitals and outpatient clinics where it began into new places—like general hospitals, hospices, shelters, and schools.

These are all forms of *secondary prevention*—helping those who are at increased risk for psychological problems—because of acute crises like war, as well as chronic conditions like poverty. If society paid as much attention to the *prevention* of emotional distress as to its *treatment,* the economic and social savings would be enormous. And because art is a normal part of everyday life, art therapy is an especially good way to promote mental health.

For that reason, it is an extremely compatible modality for *primary prevention*—facilitating *wellness*. For example, the editor of a book about art therapy with families in crisis (Linesch, 1993) has also proposed that families celebrate milestones by *making art together* (Linesch, 2000).

Although its origins were in diverse settings, the developing discipline of art therapy grew up mainly within psychiatry, in hospitals and clinics. At the 1978 American Art Therapy Association (AATA) Conference, Bernard I. Levy, with his usual flair for drama, proposed "A slogan to live by … Out of the hospitals and into the world!" In the years since then, the extension of art therapy from the clinic into the community has progressed steadily, reaching new people in new places and still expanding.

Some of this widening scope will be described in this chapter, although it is far from encyclopedic. The resources noted in each area are representative examples I have come across in my own journey and do not pretend to be inclusive.

Medical Art Therapy

The idea that art can promote physical healing is ancient **(DVD 10.1)**. Images in their tombs show Egyptians painting on barges in the Nile River, taking excursions as part of their medical treatment. The awareness that art can brighten otherwise-dreary times of enforced inactivity is also not new. Adrian Hill, who coined the term *art therapy* in 1942, painted his way through a tedious convalescence in a tuberculosis sanatorium **(A)**.

That art can give meaning to a life twisted by trauma was eloquently demonstrated in the work of painter Frida Kahlo. Her spine and pelvis were crushed in a bus accident at age 18, leaving her with chronic pain and the constant threat of illness. As she told her biographer (Herrera, 1983), "The only thing I know is that I paint because I need to." On the **DVD** you can see excerpts from Kahlo's diary, her own self-therapy in poetic words and images, as, toward the end of her life, she faced the amputation of a leg **(B)**.

Since making art comes naturally to suffering artists, it makes sense that more and more patients dealing with illness and injury are receiving art therapy as part of their treatment. A head trauma patient admitted to Metro Health Center in Cleveland might be referred to the *Art Studio,* where he will be helped to cope through creating **(C)**.

A child with severe burns **(D)** entering Davis Medical Center in Sacramento, California, may be enabled to deal with his pain through art therapy (Malchiodi, 1999a, 1999b). A stroke patient (**E)** who has lost the ability to talk might now have an opportunity to "speak" by making art (Malchiodi, 1999b).

In 1985, a medical school held a conference on art and medicine. As the only art therapist among the speakers, I knew very little about the area. After some time in the library, I was impressed by how much interesting work had been done—especially since most art therapists don't write, and what is published is only the tip of the iceberg of actual practice. In 1993 an entire issue of *Art Therapy* (the journal of the American Art Therapy Association) was devoted to *medical art therapy*, defined by the editor as the "use of art therapy with individuals who are physically ill, experiencing trauma to the body, or undergoing aggressive medical treatment such as surgery or chemo-therapy." The author of that definition has since edited two books, about work with children (Malchiodi, 1999a) and adults (Malchiodi, 1999b).

As in psychiatric settings, medical art therapists usually work as part of a team. The difference is that the primary problem for which the person is being treated is not psychiatric but physical. That is not to say that art therapists are not concerned with the psychological effects of the illness. Being sick, being treated, or having surgery—like being old or being blind—has powerful effects on mind, mood, and self-concept, and art therapy can help to enhance medical care in a variety of ways **(F)**.

Art in Medical Assessment

A patient's artwork can provide a much-needed window on the mind for those involved in the treatment. For example, the good social skills of Susie, a woman with Alzheimer's disease (**G**), masked the cognitive deterioration **(Figure 10.1)** that became dramatically evident to her art therapist **(Figure 10.2)** in her drawings **(H)**. Art is often used to identify the extent and nature of organic impairment.

Figure 10.1 Susie's drawing early in Alzheimer's. Reprinted from *Arts in Psychotherapy,* vol. 11, pp. 165ff, 1984, with permission from Elsevier Science.

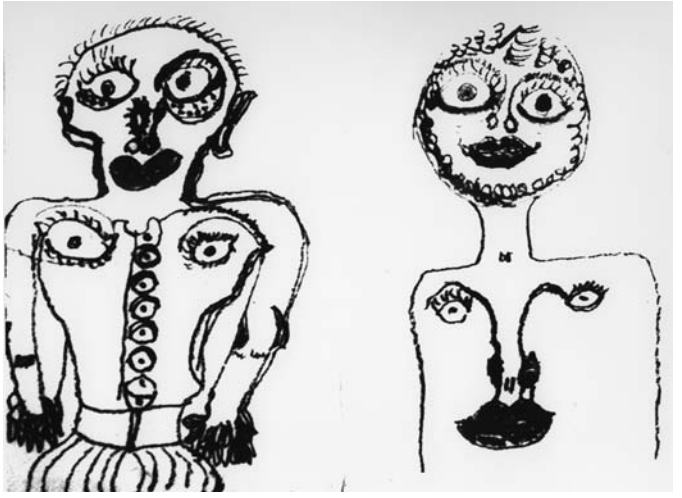

Figure 10.2 Susie's drawings later in the disease process. Reprinted from *Arts in Psychotherapy,* vol. 11, pp. 165ff, 1984, with permission from Elsevier Science.

Art can also sensitize medical professionals to a patient's feeling about his illness and treatment. A boy named Eddie was helped to talk about his diabetes by being asked to first draw his fears related to the illness and to then talk about the drawings **(I)**. For example, a psychologist asked children with serious diseases to draw pictures about some of the procedures they had to have—like dialysis or blood transfusions **(J)**. The drawings helped their doctors to be more empathic and therefore more effective **(Figure 10.3)**.

In a study funded by the American Nurses Foundation, Ellie Irwin and I invited children to tell stories and draw pictures before and after surgery. Body image distortions in the

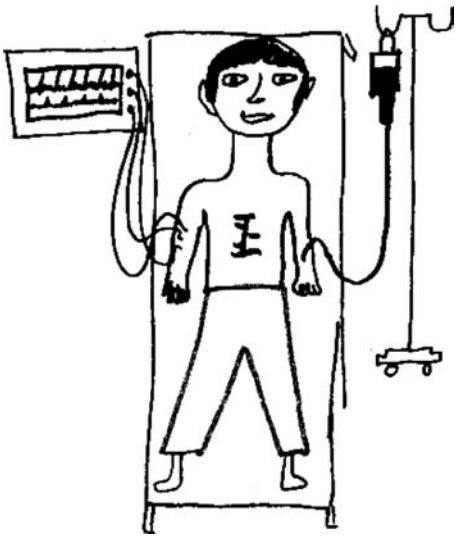

Figure 10.3 Getting a transfusion. Reprinted from *Arts in Psychotherapy,* vol. 7, p. 31, 1980, with permission from Elsevier Science.

drawings showed how *anxious* each child was, allowing parents and professionals to better prepare them for their operations. Similarly, drawings by transplant patients and their families reflected how much *stress* they were feeling about cardiac catheterization, helping the medical team in case management (Jakab, 1986).

Sometimes drawings have been used as clues to *disease processes,* and in determining a person's possible *prognosis.* Susan Bach, a Jungian analyst who discovered the prognostic value of drawings, spelled them out in *Life Paints Its Own Span* (Bach, 1990). Her student, Gregg Furth, elaborated them based on his own work with terminally ill patients in *The Secret World of Drawings* (2002).

Art Therapy for Psychosomatic Conditions

Art therapy seems to be particularly useful for these ailments, which are physically very real, but in which stress is known to exacerbate symptoms. The mind–body connection is especially visible when anxiety triggers a tension headache or a bout of diarrhea. Since these symptoms are so good at expressing repressed emotional states, art—which bypasses defenses—can help such patients to *feel what they fear.*

At a center for respiratory medicine, for example, art therapist Robin Gabriels developed an interview **(K)** in which a patient makes a series of drawings—*about his asthma.* The drawings help to identify aspects of patients' coping styles that need to be addressed in order to promote a good recovery (Malchiodi, 1999a).

Similarly, asking stutterers to *draw the stuttering episode* helped a speech therapist to formulate a more effective treatment plan (Jakab, 1970). Although it is not a psychosomatic disorder, stuttering also tends to run in families, probably reflecting an inherited vulnerability. Just as its occurrence can be triggered by stress, it can disappear with relaxation. I have noticed that stutterers are often *fluent* while they are using *contact media,* like clay or finger paint (**Figure 10.4**). Similarly, an art therapist serving people with *rheumatoid arthritis* wrote: "all my patients reported at least *partial abatement of physical pain* when painting or sculpting" (cf. Malchiodi, 1999a).

Figure 10.4 A stutterer relaxes while finger painting.

The sensorimotor aspects of working in art are indeed relaxing, as is the focus on creating—one of many reasons why art therapy is often used for children with *enuresis* or *encopresis* like Amy, Alan, and Randy. Art offers a way to "let loose" for people of all ages with many types of intestinal motility problems, from *chronic constipation* to *irritable bowel syndrome*. Since family life is greatly affected by these disorders, *family art therapy* may be the treatment of choice, as in Landgarten's work with the family of an encopretic child (Landgarten, 1987).

A Child With Encopresis: JERRY (11)

One day, Jerry, a partially sighted boy suffering from encopresis, made a head using plasticine **(L)**. Since he had chosen to use a single color, his limited vision made it very hard to see where to put the facial features. Indeed, he was quite upset with his finished product, saying that the head looked "all messed up."

Drawing on my knowledge of art materials, I suggested that it might be easier if he made the features with clay that were of different colors than the face. His first effort was only slightly more satisfying **(M)**, but he persisted, and eventually was able to make a large head of a man, with a moustache and beard like his father's, finally saying that it *was* his dad. He was much more satisfied with it than he had been with the first **(N)**.

He also went on to use the difference between the two heads in a most creative way, playing out a story. Jerry called the first head "A Little Squished-up Man With a Little Squished-up Face," and the second "A Big Man With a Big Face." In addition to his visual impairment, Jerry had a growth hormone deficiency that actually made *him* look "squished-up." In the story, the little guy ended up killing the big one, who has been very critical of the smaller fellow (**Figure 10.5**).

Jerry had finally found a way to play out, using the two heads, his angry death-wishes toward his father, whom he held responsible for his mother's desertion of the family following a series of violent fights. It was likely that his anal "messing" was an unconscious expression of this hostility, directed partly toward the caretaking parent who literally had to *clean up the mess*.

Figure 10.5 Jerry making a wire sculpture.

At the end of the session, Jerry said that the little guy in the story was *wishing* for something that was hard to say. After much encouragement on my part, he whispered, "blind." Then he said there was another word he was also finding hard to say, which turned out to be "handicapped." I wondered if the little boy in the story was wishing to get rid of those, and he nodded vigorously in the affirmative **(O)**.

I asked if he had any idea why the little boy had that problem, and he whispered, "'Cause he's bad!" I asked if he was bad for wanting to kill the big guy, and he nodded yes. This suggested that the little "squished-up" person was in such a bad physical state *because* he was so angry, and that his blindness was seen as a punishment for his badness. In this instance, as with Jane and Larry in Chapter 9, the child attributed his disability to punishment for "scary mad wishes," a term coined by Fred Rogers of *Mister Rogers' Neighborhood* (PBS), which I found useful with people of all ages. The wise lyrics to the song, "Scary Mad Wishes Don't Make Things Come True," are so important because the fantasy of power is pervasive, respecting neither age nor intellect.

Art Therapy in Trauma and Rehabilitation

When a person has just suffered a physical trauma, including accidental injury or surgery, making art can help. A massive shock to the system elicits powerful feelings for which words are weak, but for which art can be a release. Art helps both to express and to contain otherwise overwhelming emotions. In one hospital where burn patients have had art therapy for over 20 years, a protocol was developed for *art therapy in medical trauma settings*.[1]

Traumatic injuries, like severe burns or car accidents, are usually followed by long periods of anguish, pain, disability, and treatment, often with uncertain outcome. Art therapy can be helpful at every stage, from the shock of the initial trauma to the long and often discouraging process of rehabilitation (**DVD 10.2**).

In medical hospitals and rehabilitation institutes there are now more art studios like the one in Cleveland, Ohio, noted earlier (Malchiodi, 1999b). The Cleveland program was started in 1967 by psychiatrist George Streeter and art therapist Mickie McGraw (**A**)—whose own life in a wheelchair since contracting polio at age 11 inspired her to bring the healing powers of art to others (**Figure 10.6**).

Figure 10.6 Mickie McGraw in the art studio.

Sometimes making art is self-initiated, as in the work of Frida Kahlo, whose pain was transmuted by the injured artist into haunting self-portraits **(B)**. Ophir, a 5-year-old Israeli boy, had never been interested in art before, but after an accident that left him "temporarily handicapped," drawing became his chief form of "self-rehabilitation."[2] Since normal anxieties about being artistic are exacerbated by physical complications, however, most patients need the encouragement and assistance of an art therapist.

The logistics of helping a bedridden patient in traction to create can be formidable. However, even when a person's faculties are greatly reduced, some kind of art expression is usually possible, with creatively conceived adaptations and well-designed assistive devices. Even quadriplegics can be enabled to create images by using *computers.*[3] When a young man named Peter became so disabled that he could no longer hold a brush, art therapist Rita Simon supported his hand, sensitively following his instructions.[4]

Group art therapy can be especially helpful, since people with the same disorder benefit from sharing feelings and frustrations and can often do something creative to cope. A group of young adults in a rehabilitation institute formed a production company named *Wheelchair Accessibles.* Together they made a videotape—an artistic way to deal with the helplessness and anguish of their situation (Bejjani, 1993).

Led by art therapist Diane Rode, through Mt. Sinai's Child Life & Creative Arts Therapy Department, pediatric patients have been making videotapes about their conditions for over a decade in Through Our Eyes Productions, as well as a child-operated closed-circuit TV station, *Kidzone TV* (www.mtsinai.org).

At Bellevue Hospital, Director Irene Rosner-David (**Figure 10.7)** has led the Creative Arts Therapy Department since 1978. It provides services for many patients, from those with AIDS to those in isolation for tuberculosis (Malchiodi, 1999b), to those with spinal cord injuries. In *A Look at Medical Art Therapy* (Kahn & Illusiorio, 1990), two graduate student interns filmed Rosner working with a young man named Eddie, quadriplegic following

Figure 10.7 Irene Rosner at Bellevue Hospital.

an accident. On the **DVD (C)**, you can see her helping Eddie as he learns how to paint holding a brush in his mouth (cf. **DVD 7.2D** for earlier stages of their work together).

People in rehabilitation do not always get better but often must, like Eddie, learn to live with a condition that constricts their lives. Many suffer from progressive disorders, such as *multiple sclerosis* or *amyotrophic lateral sclerosis* (ALS, or Lou Gehrig's Disease). Art therapy is especially helpful in coping with *chronic disease processes*, since art can fill long, tedious periods of time with creative activity, as well as helping patients to adjust as best they can. Milton M., homebound for nine years with multiple sclerosis, "came alive" when a young art therapist was able to engage him in a playful drawing dialogue (Robbins, 1980).

Art Therapy for Healing

The use of *mental imagery* to combat pain and disease is one of many interventions in the increasingly popular realm of *alternative* or *complementary medicine*. Some visualization techniques include *drawing* as well as mental imagery, as ways for those with cancer, for example, to mobilize their immune systems. Most approaches to the use of imagery in healing are focused: the patient visualizes or draws his disease and his body's efforts to fight it (Achterberg, 2002). Art therapists have also worked in this area as well (Dreifuss-Katan, 1990; Lusebrink, 1990; Waller, 2007).

In a study presented at an imagery conference many years ago, a researcher asked subjects to *visualize* their T-cells multiplying. He then asked them to *draw* what they had imagined. The slides he showed of their blood—drawn before and after the art activity—were so dramatically different that even a skeptic could not deny that creating images had somehow helped to increase the number of "fighter" cells. It was a powerful demonstration of the healing potential of imagery, especially when linked with art.

Many uses of art for healing are not so directive, but however it is employed, the idea is that making art can have a positive impact on the immune system—that creating affects not only the psyche, but the soma as well. The field of *psychoneuroimmunology*[5] is in its infancy, but findings so far are very encouraging. While I was revising this chapter, for example, a

study conducted demonstrated that art therapy reduced pain and anxiety in cancer patients, as well as fatigue.[6]

The National Center for Complementary & Alternative Medicine, which is part of the National Institutes of Health, recognized art therapy as an alternative or complementary therapy in 1993. A recent well-designed study of mindfulness-based art therapy for cancer patients demonstrated that the intervention led to decreased symptoms of distress and significant improvement in key aspects of health-related quality of life.[7] Similarly, Alternative Therapies in Health & Medicine (www.alternative-therapies.com) invited papers in the creative arts therapies.

As noted in Chapter 2, one of the most rapidly developing areas in the past few decades has been *arts medicine.* The Society for the Arts in Healthcare is comprised of physicians, nurses, artists, and arts therapists. The delivery of the arts to patients of all ages in medical hospitals (Rollins, 2004) has dramatically increased with the development of *artist in residence* programs (Rollins & Mahan, 1996) as well as the field of *child life.*

Art therapists have been reporting for some time on the use of art for release, solace, and healing, since Adrian Hill's pioneering work in sanatoriums on *Art Versus Illness* (Hill, 1945) and *Painting Out Illness* (Hill, 1951) **(DVD 10.3)**. Art therapist Suzanne Lovell got better by fighting her illness through movement and art, telling her story in a video (Lovell, 1990), and describing the method in a book chapter (Lovell in Virshup, 1993). You can see and hear her telling part of her story on the **DVD (A)**.

Artist Darcy Lynn battled her *lymphoma* with her art, making drawings in intensive care after surgery—and during the long process of pain, fear, hope, and recovery **(B)**. Art therapist Wendy Miller **(C)**, who runs an integrative arts medicine studio, wrote a pamphlet for medical personnel about the self-therapy through art that Lynn had accomplished (Miller, 1996). You can hear and see both of them on the **DVD**.

In 1993, organ transplant recipients from all over the country were invited to submit artwork done before and after their surgery to a competition called "Art for Life" sponsored by a Pittsburgh pharmacy. As a judge for the exhibit, I had the good fortune to see all of the work submitted, which was unbelievably powerful. Even more persuasive were the words of the artists that accompanied the slides **(D)**. I came away convinced, like many of them, that making art had accelerated their recovery. Perhaps it was because the physiological transformation they had gone through—from dying to living—was so vividly reflected by similarly dramatic transformations in their art.

Art Therapy for Terminal Illness

Patients who are dying are usually dependent on caregivers, so that taking charge of art materials and creating their own images can restore a sense of efficacy—at a time when they are otherwise helpless **(DVD 10.4)**. We do not know to what extent art therapy can affect the progression of a terminal illness, but we do know that creating something new—when the world of the self is shrinking—is beneficial. Roger, an AIDS patient in an era before medications were effective, talks about his art therapy **(A)**.

In clinics, hospitals, and *hospices,* even in their homes, people of all ages who are facing deterioration and death are being helped to cope by drawing, painting, and sculpting (Pratt & Wood, 1998; Rogers, 2007; Waller, 2007).

In addition to helping a dying patient to master his feelings through making art, the therapist plays a special role at a time "when art is all there is." By helping a person to cope with the illness while not being involved with the medical treatment, the art therapist

participates in a uniquely *shared journey,* and bears witness as the patient comes to terms with his fate—with the help of art and her presence (Waller & Sibbett, 2005).

For youngsters with cancer, making art is a natural way of "helping normal children cope with abnormal circumstances."[8] Rachel, dying of leukemia, shared her spontaneous drawings and writings with her home/hospital teacher (Bertoia, 1993).

Usually the creative activity is introduced by an art therapist, as in work with AIDS patients (Landgarten & Lubbers, 1991). Occasionally, art is provided by a physician, as in the *painting therapy* for cancer patients offered by a doctor in Germany (Hauschka, 1985). For a dying person, when art making is watched over by a sensitive clinician, even deeper healing can take place. In *Cancer Stories*, Esther Dreifuss-Katan (1990) offers eloquent examples of her subtitle: *Creativity & Self-Repair* (cf. Waller & Sibbett, 2005).

Although the body may not be curable, art is a wonderful way to repair the injured soul. Art, after all, is an expression of the human spirit, and both have their own kind of immortality. In addition to work with patients, art therapy can also help the family—during the dying process as well as after their loss. Three generations, for example, were helped to deal with their feelings about a terminally ill grandparent through family art therapy (Landgarten, 1987). Dreifuss-Katan (1990) also describes art therapy with the grieving family. Indeed, all of the arts help people to face death and to deal with grief (Bertman, 1999).

Both children and adults with life-threatening illnesses rarely give up all hope of recovery, no matter how faint. One of the bravest women I have ever known was also one of the best art therapists I had the privilege to train. In Susan Aach-Feldman's battle with ovarian cancer, she often turned to making her own art.

Fighting Cancer With Art and Imagery: SUE (37)

Susan Aach-Feldman was a young art therapist who did brilliant work with blind children **(B)**, and who, at age 39, died long before her time. Her fatal illness, ovarian cancer, was diagnosed two years before it finally conquered her body; perhaps delayed by the brave spirit she mustered to fight it.

While still in the hospital following her first operation, Sue asked for art materials, and we would talk about her drawings during my visits. Actively using imagery as a tool in her fight against the disease, she worked at visualizing the cancer cells and her immune system. Sue also drew bold and powerful pictures in her sketchbooks, trying to beat the challenge of cancer as creatively as she had met the challenge of helping children with multiple disabilities.

One year after her first operation and a course of chemotherapy followed by a welcome period of comfort and energy, Sue was due to have a routine follow-up called *second-look surgery.* Just before she went into the hospital, she requested a meeting at my office. During an intense two-hour session, she drew and discussed a series of three chalk drawings, which, like her courageous spirit, were realistic, yet full of hope.

The first was a glowingly healthy portrait of her body, "What's Happening Inside: Visualizing the Best" **(C)**. The second was a representation of her T-cells (**Figure 10.8)** entitled "My Fighters: The Swordsmen" **(D)**. And the third was a boat plowing its way through rough waters, "The Narrow Path: An Odds-Beater on a Sturdy Ship" **(E)**.

Sue did beat the medical odds, staying alive more than twice as long as the doctors had predicted before succumbing to the cancer. Though there is no way to prove it, I believe that Sue's passionate use of imagery and making of art helped to extend her life. As noted earlier, some studies support the power of mental and artistic imagery to strengthen the human immune system. And there is considerable evidence that such a spirit, a will to live

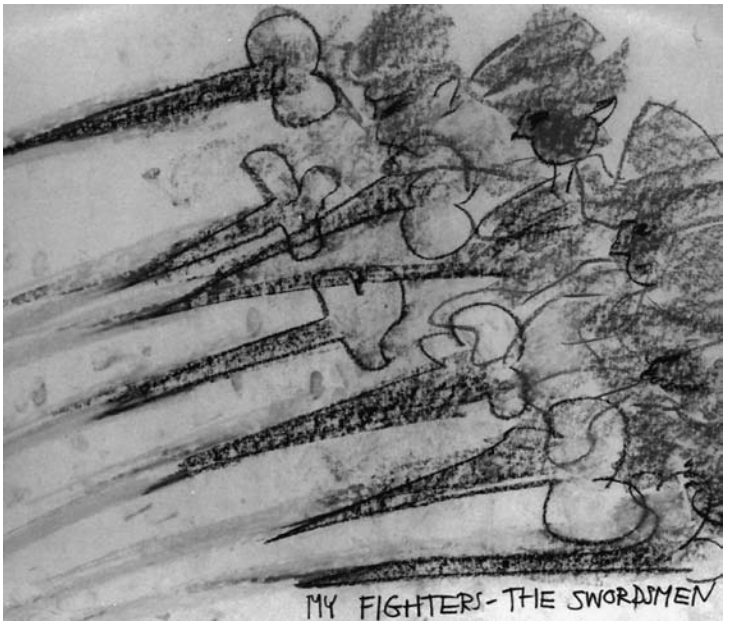

Figure 10.8 "My Fighters: The Swordsmen" (T-cells).

so strong and vibrant—while it probably can't win—may well slow down the progress of even a terminal illness.

Art Therapy for Bereavement (DVD 10.5)

When you lose a loved one you need to grieve, to deal with feelings like guilt about surviving, and anger at being abandoned. Making art allows for a visceral expression of feelings too raw to put into words. I remember how badly I needed to paint after my friend Peter's sudden death, when I was about to turn seventeen, which I described in Chapter 1. Painting the picture did not take away the pain of loss, but it helped to release some of the rage and anguish I was feeling, which had made me literally ill with a high fever after the funeral.

Years later, I was surprised that my mother—who was not an artist—became deeply involved while working with clay after my father died, sculpting his head **(A)**. She was able to discharge her feelings by squeezing, forming, and caressing the clay, while at the same time creating a concrete image of her lost spouse—a lasting memorial. Just a week after her death, I found that making a series of "free association" drawings was amazingly helpful to me in the work of mourning, as detailed in Chapter 1.

There is more sensitivity now to the need for crisis intervention for losses—giving help at the time of the trauma. If I had been offered art therapy after having a stillbirth—as one art therapist did for women following *perinatal death*—I might have been spared considerable psychological pain. As with a miscarriage, the loss is to all except the mother, "grief unseen" (Seftel, 2006).

Children who have lost parents have been helped to work on their grief through art therapy support groups in schools (Virshup, 1993) and in hospices (Wadeson, Durkin, & Perach, 1989). Art therapy has been used in *grief support groups* (Rogers, 2007) in settings all over the country, from Philadelphia **(B)** to Michigan, where art therapist Barbara McIntyre not

only provides art activities for bereaved children and other family members, but also helps them to create plays about grieving. On the **DVD** you can see excerpts from one such production, "A Bridge to Tomorrow" **(C)**.

For many years, art therapist Marge Heegard has created *drawing workbooks* to help children who have suffered losses, initially to help her own grandchildren. Her 18 books help children to draw and think about many topics, from separation and divorce to illness and death (Woodland Press and Fairfield Press). She has also written a guide for professionals leading support groups (Heegaard, 1996). On the **DVD** you can see her as she leads such a group **(D).**

Sandra Graves Alcorn has for many years offered art therapy to mourners through churches and funeral homes. Individuals and families, who might not otherwise have sought help, could do so through the *grief counseling service* she founded in the early 1980s. She later organized three other forms of art counseling intervention to deal with murder and suicide. She also created a compassionate workbook for bereaved adults titled *Expressions of Healing* (Graves, 1994). On the **DVD** she is helping a child who has recently lost his mother in an accident **(E)** (cf. also Meijer-Degen, 2006).

The loss of loved ones is a *normal crisis*, which if not mastered, can lead to depression. Art activities can be a form of *prevention*, as vital in mental as in physical health. Seven-year-old Christopher knew that I helped children through art. After his mother committed suicide, he requested a visit to my art room and asked to come back a year later.

A Child Requests Art Therapy After His Mother Kills Herself: CHRISTOPHER (7)

Since I was a friend of the family, Christopher knew that I helped kids with their worries through art. In fact, after his mother's prior unsuccessful suicide attempt, he had proudly shown me his "magical" creation. Using cut paper and glue he had created a flag, writing "Save Me" **(F)** on one side and "Trouble" on the other **(G)**. Inside, he had hidden a cardboard hatchet and knife. It was a poignant attempt to keep her from destroying herself with his protective weapons.

Sadly, Christopher's fears were all too well founded. His mother's melancholia, in an era before effective antidepressants, eventually won out and she did kill herself. After the funeral, Christopher asked if he could come to my office. His father, concerned about the boy's silence regarding the tragedy, brought him to the clinic where I worked. I, feeling sad and helpless about the death of a woman I had known for many years, was pleased to do what little I could to help.

Christopher's visit to my art room was just a few weeks after his mother's death. He worried about getting messy with finger paint or chalk, because "my Mommy would yell at me." Projecting an image of "A Dog" **(H)** onto his scribble, he said it must be the dog he had wanted so badly, but was not allowed to have because of his mother's illness.

Christopher then made a dark, messy finger painting, commenting anxiously on how angry his mother would be if she could see him. He wondered aloud as he painted whether she was angry at him, and if his being bad or naughty or wanting the wrong things (like the dog) had anything to do with her leaving him.

His story about the finger painting, as he drew lines in it with a stick, was that it was "A Road, but," he continued, "you'll never find your way out … No one can stop me … They'll never find their way out. They'll feel so sad … They'll be stuck there forever." I asked what "they" would do. Christopher placed his hand in the black paint, lifted it up to show me, and then smashed it onto the paper, splattering the paint. He had certainly accomplished a lot in his single hour.

One year later, Christopher asked to come in again. This time he symbolically represented his mother's suicide in his drawing: a pink person "falls" off a road **(I)** as she had "fallen" off a bridge. Later, he dramatized with clay and clay tools a crash, an emergency, and an operation in which he, as the doctor, magically but unsuccessfully tried to restore the injured patient. He accomplished a great deal in his second hour too.

Making art gave Christopher a way to release his overwhelming anger and frustration. It also gave him an opportunity to clarify the event, and to cope with the painful reality he needed to accept. Thirty years later, a grown-up Christopher called and asked me to send him a copy of the book in which I first told his story, since the pain had been so great that he was having trouble remembering his mother's death and how he dealt with it. I found it fascinating that, having needed to repress so much of what happened to him, he remembered the art sessions and wanted to relive them as a way of trying to reconnect with his tragic loss.

Bereavement is a particular kind of personal crisis, in which art can be therapeutic. Making art can also be therapeutic when there is a crisis in the community.

Art as Therapy in Times of Crisis

War and Combat

Art as solace in times of anguish is older than the field of art therapy. Some events are so devastating that words fail, and images become the best way to say what presses for release. In a Nazi concentration camp, for example, children made art to imaginatively escape from the terrible place in which they found themselves (Volavkova, 1962; Jewish Museum of Prague, 1993). They were taught by pioneer art therapist Edith Kramer's mentor, an artist named Friedl Dicker-Brandeis (Makarova & Seidman-Miller, 1999). On the **DVD (10.6)**, you can hear Kramer talking about Friedl and what she learned from her when both of them offered art to refugee children coming into Czechoslovakia **(A)**.

While the children's poetry and art has few images of terror and many wishful ones **(B)**, the adult artists who were kept busy making propaganda images for the Nazis during the day secretly drew pictures at night to record the truth of what was happening (**Figure 10.9)**. These pictures, some of which survived the war, are extremely powerful (Green, 1969) **(C)**.

Two Jewish adolescents in hiding before dying in the Holocaust left their journals for posterity. One is Anne Frank's famous diary—a word portrait. The other is *A Diary of Pictures* by art student Charlotte Salomon, a series of paintings she made to deal with the unthinkable events that were happening in her family and in her world (Felstiner, 1997). Her paintings and writings also survived the war **(D)**, and have been exhibited at many museums as well as being published in a book, *Life? or Theater?* (Salomon, 1998).

Since the State of Israel was born in 1948, both Arabs and Jews have lived in a constant state of strife. Children in shelters drew pictures while bombs burst outside during the Six Day War **(E)** (Kovner, 1968). For many years, Julia Byers, while chair of the Expressive Arts Therapy Programs at Lesley University, has traveled to the West Bank and Gaza to help Arab and Israeli children through art therapy.[9]

During the First World War, the faces of many soldiers were badly disfigured by chemical warfare. I will never forget hearing a plastic surgeon tell the moving story of a *sculptress* who carefully made *masks* of the soldiers' pre-trauma faces from photographs. In an era before reconstructive surgery, wearing the masks allowed these maimed men to function in

Figure 10.9 A concentration camp execution.

the world without excessive shame. In 2001, an artist donated her skills to families who had lost members in the terrorist attacks, offering to make portraits of the person from a photograph. You can see and hear her on the **DVD** telling why and how she did what she did **(F)**.

During the Second World War, the Red Cross sent *logbooks* to Americans in prisoner of war camps. The prisoners not only wrote in them, they also made drawings and paintings. Creating images—of people and places they missed—was a way to hold onto good memories, and to relieve months or years of tension and boredom. On the **DVD (G)**, you can see and hear more about how helpful those logbooks were from some of the soldiers who created in them (www.merkki.com/art.html).

The trauma of war does not disappear with the end of combat, but is often carried in the mind and body in the form of *posttraumatic stress disorder (PTSD),* which affects civilians as well as soldiers. Thirty years after an atomic bomb was dropped on Hiroshima, a Japanese TV station asked survivors of the attack to submit drawings of their memories. They were astonished by the response, as hundreds of adults welcomed the opportunity to deal with the still-painful trauma by creating images **(H)** (Japan Broadcasting Corporation, 1977).

Vietnam veterans, who suffered massive culture shock as well as the trauma of combat, have been helped to heal through art therapy; their own art as self-therapy is on display at the National Vietnam Veterans Art Museum in Chicago (www.nvvam.org). On their website art therapy is cited as helping in their efforts to heal. You can hear some of them talk about their art on the **DVD (I)**.

Because of the nature of contemporary combat and the kinds of disabling injuries soldiers have suffered in places like Afghanistan and Iraq, PTSD is becoming tragically more common. Making art is one way to achieve some control over the intrusive imagery of flashbacks (Horowitz, 1983). In fact, art therapists at Veterans Administration hospitals, including Walter Reed Army Medical Center in Washington, D.C., have long helped veterans deal with PTSD through art.

Natural Disaster and Violence

Art therapy is often part of public and private efforts to provide *crisis intervention.* This is a particular form of *secondary prevention,* offering help to those who are in the throes of responding to overwhelming events. Like medicating at the first sign of an infection, early clinical intervention can sometimes prevent more serious and prolonged emotional damage. Sometimes the traumatic event is a natural disaster, dislocating and frightening people of all ages, who are often left homeless and injured.

When a devastating hurricane hit the Miami area in 1992, art therapists were on the scene, offering their help to people in shelters. When a tornado decimated a Kansas town in 1991, a teacher helped her students to deal with the trauma by making art. Children at a mental health clinic in Armenia were encouraged to make pictures after a 1995 earthquake. The therapists were able to monitor the children's recovery by observing changes in their art and its "colors of disaster."[10]

In recent years, art therapists have made repeated trips to New Orleans, which not only helped the children **(J)**, but also led to an exhibit in 2007 at the New Orleans Museum of Art: *Katrina Through the Eyes of Children* (www.katrinaexhibit.org). Art therapists have also gone to India, helping children on the mainland and on the Andaman Islands after a devastating tsunami in 2004 wrecked their world (www.sanghaworld.org).

When a plane crash in Pittsburgh left no survivors, an art therapist helped students to deal with their feelings through drawings (Kunkle-Miller, 1995 *AATA Conference Proceedings*). When a train collided with a school bus in Israel, killing 22 and injuring 15, making art helped youngsters cope with the trauma.[11] When a nuclear reactor core melted down on Three Mile Island in 1979, children were invited to draw their fantasies about radiation, and I was part of a team analyzing the drawings and planning interventions.

Children who had witnessed a shootout between the police and a radical political group were helped to deal with their fears and feelings through art therapy (Landgarten, 1981). A 1995 terrorist bombing in Oklahoma killed or injured many innocent people. The clinician in charge of helping the survivors to deal with their posttraumatic stress reported that art therapy was especially helpful to people of all ages.[12] A recent edited book about art therapists helping survivors of political violence is most welcome in this turbulent era in which we live (Kalmanowitz & Lloyd, 2005).

Community Tensions

Sometimes these crises reflect racial tensions, like the *riots* in many American cities after Martin Luther King Jr.'s assassination in 1968. Children in one torn-up Washington neighborhood were helped to sort out what they had witnessed by writing and illustrating a booklet about it[13] **(K)**. In Pittsburgh, a biracial group of artists and arts therapists got together and worked all summer at a joint volunteer creation—the *Martin Luther King Freedom School.* Classes met in a church and a neighborhood center, where people from 2 to 82 came to dance, sing, act, paint, and sculpt—finding hope and community in shared creative activities.

In 1992, a vivid image of police brutality in Los Angeles played repeatedly on TV screens across the country, fanning embers of resentment that burst into flaming riots following a court decision. When groups moved in to try to contain psychological damage, art therapy was one of the modalities used to help. Because it was so effective, the local art therapy association was asked by the city to write a guide for artists and teachers who volunteered their services (Virshup, 1993). Designed to help those offering art to do so safely, the guide is use-

ful for any art therapist consulting to those with no clinical background, who are providing art experiences to vulnerable individuals.

Since our world is now so full of trauma, the American Art Therapy Association published *Using Art in Trauma Recovery With Children* (AATA, 2005), which is available on the AATA website (www.arttherapy.org).

People and Families in Crisis

The inevitably disorganizing effects of family disruptions like *divorce, separation, custody battles, stepparents,* and *blended families* have brought many children and adults to clinicians for treatment. Art therapy has been helpful not only with individual clients, but also with families, since even when people are not speaking to each other they can still draw. During the process of *divorce,* art therapy can help couples to communicate, and is also useful in *custody evaluation* (Landgarten, 1987). *Family art therapy,* (including *multiple family art therapy*) has helped *single-parent households* (Landgarten, 1981; Linesch, 1993), as well as the *parentified grandparents* who often bear the burden (Riley & Malchiodi, 2004).

Art therapy has also been used in the most recent attempt to stem the tide of family breakdown—*family preservation*. One such program, Parents & Children Together, was an outgrowth of one of the most original efforts to bring the benefits of art therapy to a wider community—Free Arts for Abused Children. Started in 1977 by Los Angeles art therapist Elda Unger and other artists, it is a program in which volunteers are taught by art therapists to offer art to vulnerable individuals (Virshup, 1993). It has since expanded to several other cities, serving thousands of children (www.freearts.org) **(L)**.

When families fracture, some children end up in *foster homes.* Art therapy has been used to help these dislocated youngsters deal with their inevitable ambivalence, and the fragile attachments to which they cling. These "rejected" children, who have been neglected, deprived, and sometimes literally abandoned, can articulate the mixed-up feelings they can't put into words through art (Betts, 2003). Art therapy is helpful to children from violent homes (Malchiodi, 1997), who are often unable to speak of what they have endured. I once treated a child who had witnessed a terrible sight: watching her mother shoot and kill her younger brother.

Art Therapy for Posttraumatic Stress Disorder (PTSD): JACKIE (7)

Jackie **(M)** suffered from nightmares and intrusive waking imagery. She was also miserable when awake, because her grumpy behavior with both adults and peers left her feeling very lonely. She had gone for play therapy for almost a year, with no change in her symptoms. Her child care worker, who had attended an art therapy workshop, finally decided to drive a long distance, in order to see if art therapy might help.

At age five, Jackie had watched her mother shoot and kill her younger brother. Like most children with abusive parents, Jackie could not safely know or acknowledge anger at her mother. She was afraid of losing what little good feeling she clung to on her infrequent visits to the jail. But she could safely direct her rage at me (as the mother in the transference) in "ugly" drawings of "Dr. Rubin's Face" **(N)**.

For several weeks, she put signs on my office door, warning other children not to believe what I said, and projecting her own envy and neediness onto me, accusing me of being "a beggar." **(O)** Thus, using art, she was able to work through her confused feelings about herself and others. Jackie eventually integrated good and bad images of both of us, and was able to leave therapy with a warm attachment **(P)**.

Family art therapy can also be helpful to people of all ages suffering from *domestic violence* (Riley & Malchiodi, 2004). Battered women, a long-silent group, are finally beginning to speak up and to be treated (Wadeson, Durkin, & Perach, 1989). Sometimes they end up leaving abusive situations, and may be able to move "from entrapment to empowerment" through art therapy (Virshup, 1993).

When people flee trouble at home, they sometimes end up in *shelters*. Art therapy, so adaptable, portable, and allowing instant expression, is finding its way into many such new and challenging settings. For a person whose life is in chaos, art can provide order. For someone in a state of impermanence, art can supply something durable. So it is not surprising that people are receiving individual and group art therapy in places like soup kitchens (Liebmann, 1996), transitional "bridge" housing programs, and shelters for the homeless (Linesch, 1993; Virshup, 1993).

Some of the newer settings for clinical work with people in crisis, like halfway houses and homeless shelters, are the result of changes in the psychiatric hospitals where art therapy began. With the closing of many state hospitals and shortened stays in others, patients with chronic mental illness and developmental disabilities have moved into the community, opening new doors for art therapists. Art therapists themselves have also created new doors, such as the *open studios* that have been developed in a number of urban neighborhoods[14] **(Q)**.

Displaced Persons

Like the runaway adolescents in one shelter who sorted out who they were by making masks (Virshup, 1993), people who are dislocated are confused about their identity. Being "a stranger in a strange land" is hard, even if the person has left a dangerous situation.

The German children who fled to Czechoslovakia in the late 1930s were fortunate to be able to create with art therapist Edith Kramer and Friedl Dicker-Brandeis. Five adult refugees were lucky to make art for two hours a week with Henry Schaeffer-Simmern when they first came to New York, as he did, fleeing the Nazis. "The unfolding of [their] artistic activity" under his guidance probably increased their self-confidence, as they adjusted to life in a new country (Schaeffer-Simmern, 1961).

Art therapy itself has been used with many immigrants, because art is a truly universal language. For example, migrant women and their children worked together in art as a way to be closer (McGee & Gonick-Barris, 1979 *AATA Conference Proceedings)*. American art therapists have helped refugees from many different places, such as the West Indies, Cambodia, and Central America, as have our colleagues in Great Britain (Dokter, 1998) and elsewhere, like the Netherlands **(R)**.

Economically Disadvantaged Individuals

Another group of people who are at risk for social and emotional disorder are those who are poor, whose stress is chronic. The artist's role as a social change agent is not new. In 1931, a British artist named Jeannie McConnell Cannon volunteered to work with unemployed miners and steelworkers in the most depressed area she could find—South Wales. Her modest account in the *Bulletin of Art Therapy* (1964, p. 43) is a delight to read, and a precursor for later efforts. As noted in Chapter 3, some artists taught in hospitals during the Depression under the Federal Arts Project of the Works Progress Administration (WPA). Others worked on community arts projects, like painting wall murals in poor neighborhoods **(S)** or teaching art to unemployed youth.

The 1960s and the 1970s were another period of social activism in America. At the Pittsburgh Child Guidance Center (PCGC), half of my job involved work in the community with children and families who were at increased risk for psychological problems—that is, secondary prevention. In addition to developing art programs in schools for those with disabilities, we also worked in poor neighborhoods.

At PCGC, the head of Social Group Work in 1969 was a woman named Mattie Addis. A member of our expressive arts study group, Mattie invited Ellie Irwin and me to participate in her work in poor neighborhoods, so we conducted *art and drama therapy groups* with girls in their *schools* and in a summer *day camp*. For the next few summers, I coordinated creative arts programs in two "model cities" (i.e., poor) neighborhoods. The children and their parents who participated in the arts activities enhanced both self-image and neighborhood pride.

These programs were documented in *Children and the Arts: A Film About Growing* **(T)**, designed to convey the mental health values of the arts for all children. Like an earlier film about the creative abilities of multiply handicapped blind children (*We'll Show You What We're Gonna Do!*) **(U)**, it was a form of public education—another aspect of prevention. Both films have been revised and remastered and are available with extra features on related topics from the nonprofit organization, Expressive Media, Inc. (www.expressivemedia.org).

These brief but earnest efforts used art activities to allay social and psychological distress. Increasing unrest and crime in America are leading to a renewal of neighborhood arts projects. One art therapist used *film, photography and art with ghetto adolescents* in diverse settings that included not only schools, but also a gang clubhouse (Robbins, 1995). Like basketball, art is a healthy way to get kids off the streets, and away from the drugs and crime so rampant in poor neighborhoods. When offered by trained art therapists, it can lead to the kind of internal growth that fortifies people against such temptations.

Art Therapy in Correctional Institutions

Unfortunately, many of those who have suffered poverty or abuse do not get help. Some end up committing crimes, for which they are usually not treated, but punished. Yet the only way to break what can become a vicious cycle is to make the period of incarceration one of rehabilitation. Art in prison is inevitably a constructive way to fill time, whether offered by an educator **(V)** or an artist **(W)**. When it is provided by a clinically sophisticated art therapist, it is also a form of treatment. Most inmates will not cure themselves through creativity. But some offenders can be helped to rebuild their lives through art therapy, which is becoming increasingly available in correctional institutions (Gussak & Virshup, 1997; Liebmann, 1994).

Delinquents and criminals, while often suspicious, are also troubled individuals, who are hungry for interest and attention. I remember making visits to the Allegheny County Jail in the early 1970s. I was pleasantly surprised by the inmates' enthusiastic response to the opportunity to paint, draw, and model with clay.

A few years later I received a letter from a man in a New York State prison, begging me to write his superintendent. He had discovered a love of oil painting, but was not being permitted to pursue it. I wrote, assuring the superintendent that far from being a waste of time, making art could be highly therapeutic, and encouraging him to hire an art therapist. As in other areas, there were earlier precursors.

From 1940 to 1942, for example, Schaeffer-Simmern taught art to what were then called *delinquents* at the *New York City Reformatory* (Schaeffer-Simmern, 1961). From 1963 to 1965 Tarmo Pasto (1964), a psychologist with an interest in art, had a National Institute of Mental

Health (NIMH) grant to study the usefulness of art therapy in California institutions—including the Departments of Corrections and Youth Authority. Donald Uhlin (1972), an art therapist who worked with Pasto, used projective drawings to evaluate defendants for the criminal justice system.

Although "making art in a jail setting" (Wadeson, Durkin, & Perach, 1989) has been rare in the United States, it is a growing area of service. There are all sorts of criminal art therapy clients—like the mother who killed her child, treated by Rose Marano Geiser, whose exploration of art therapy in prisons began when she was a graduate student (Wadeson et al., 1989). While we in the United States have been rather slow to scale the walls of correctional institutions (Gussak & Virshup, 1997), those in the United Kingdom seem to have been more effective (Laing & Carrell, 1982; Liebmann, 1994, 1996).

Art as Therapy for Wellness

Art as Therapy in Everyday Life

From the caveman to the Sunday painter, normal people in ordinary settings have been making art as a form of self-therapy. Sometimes it's to unwind or to relax, as a way of dealing with the stresses of everyday life. Sometimes it's to cope with a trauma—an event that is too much for the ego to assimilate. The very fact that creative activity is therapeutic is one reason for the existence and the effectiveness of art therapy.

Making art available to more people in a way that allows them to honestly express themselves is good medicine, like taking vitamins or getting regular checkups—a form of primary prevention. When I was the Art Lady on *Mister Rogers' Neighborhood*, a public television program for young children (1966–1969), my goal was to demonstrate the value of art expression for self-esteem, self-definition, and dealing with feelings (**Figure 10.10**). On the **DVD (10.7)**, you can see an excerpt from one of the shows where I visited Fred Rogers in his kitchen, showed him children's art, and made things alongside him **(A)**.

Art as Therapy for Children and Families

Public and professional education can take many forms. For example, for many years I contributed a child's drawing for the cover of a journal for preschool educators, along with a written commentary. The goal was to teach these professionals about the therapeutic values of art in the classroom. Two of the chapters in *Child Art Therapy* are "Helping the Normal Child Through Art" and "Helping Parents Through Art and Play." When I worked at the Pittsburgh Child Guidance Center from 1969 to 1980, half of my job was in *Community Services*.

This involved not only work with children and families who were at risk, but also work with *teachers, parents,* and *children*. This included things like teaching courses in the therapeutic value of art to art and classroom teachers, other caregivers, and interested parents. We also trained professionals from different disciplines to run *Art Awareness* **(B)** groups for adolescents and *Parent Play* **(C)** groups for adults, which included follow-up consultation. The following vignette is from a preschool that was attuned to children's expression of feelings through art, due to mental health consultation.

Art as Therapy in a Preschool: SAMMY (4)

Sammy's mother had just come home from the hospital with a new baby sister. She was the first girl in the family, and everybody was making a big fuss over her. Sammy did too … he

Figure 10.10 The Art Lady visits Mister Rogers (PBS). From Mr. Rogers' Neighborhood. © Family Communications, Inc. Used with permission.

helped with the diapers, kissed the baby, and told all his friends and relatives how much he loved his new sister. But Sammy was also jealous. His mother used to have much more time for him before the baby came, and now she was always busy or tired.

So one day at his preschool he drew a picture of a bird diving down toward a nest **(D)**. And he told his teacher the following story about his drawing (**Figure 10.11**): "That big boy bird's gonna knock that other one off the nest! There ain't no room for two!" Sammy could

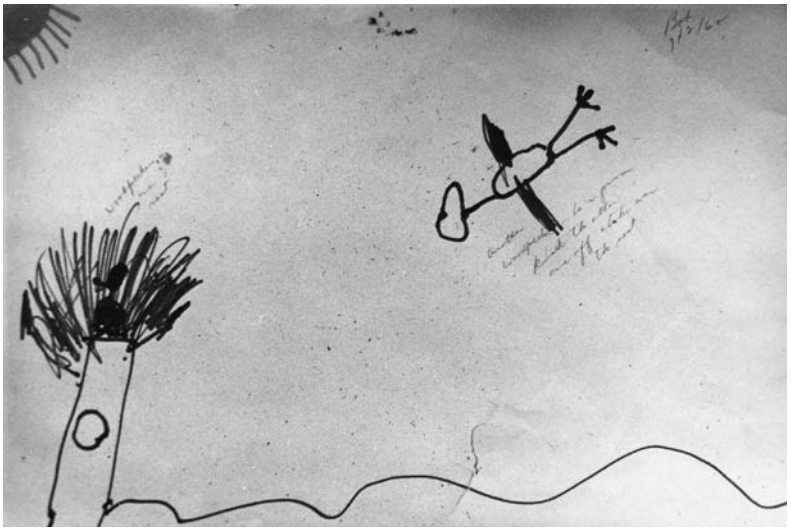

Figure 10.11 "A Bird's Gonna Knock Another One Off the Nest!"

Figure 10.12 Endless easel at the Community Arts Festival.

not get rid of his sister in reality, nor would he want to most of the time. But he could express that wish with symbolic disguise in a drawing, free of guilt or anxiety. Because his teacher had been taught that, if "scary mad wishes" are accepted with understanding, children are less likely to act them out, she could empathize with his drawing.

On a larger scale, Pittsburgh has an annual citywide arts festival where people of all ages come to look at art and watch performances. Since 1973, there has also been a place where children and families can create art themselves—the *Family Creative Arts Center,* started by Community Services of PCGC (**Figure 10.12).** On the **DVD** you can see what the many arts activities provided during the first year of the project looked like **(E)**.

Being part of the Community Services Department allowed me to spread the word about the therapeutic benefits of art to many settings, like preschools, community centers, and churches. There were *art groups for parents* **(F)**, where they created with media and, through their own experience and discussion, understood the value of art for their children. There were *mother–child* **(G)** and *family* **(H)** *art sessions*—where the activity with the children was followed by discussion groups for the adults, so they could reflect on and learn from the joint experience.

There were a variety of *pilot programs* in schools, including art activities specifically designed to promote self-awareness (*Art Awareness*), and the making of *animated films* **(I)** —which tended to be about normal concerns and fears that kids don't often get to talk about.

Consultation to art and other teachers, as well as to school guidance counselors, was another avenue for getting more health-promoting art opportunities into the classroom. Just as medical art therapy serves the primary goal of physical healing, so *school art therapy* serves the primary goal of enhancing the child's ability to learn.

Sometimes such art therapy is done with individuals or small groups who are having difficulties. There have always been a few art therapists in schools who have worked with *normal*

children experiencing temporary stress, a role pioneered by Edna Salant at the *National Child Research Center* in Washington, DC (Salant in Ulman & Dachinger, 1975).

Janet Bush's program in the Dade County (Florida) public schools has, since 1979, provided individual and group art therapy to troubled youngsters, as well as staff training for teachers (Bush, 1997). John Allan of Vancouver did art counseling in schools with individuals and groups, collaborating respectfully with teachers (Allan, 1988; Allan & Bertoia, 1992).

Sometimes therapeutic art activities occur in the classroom (Furrer, 1982), like those in *Something to Draw On* (Ross, 1997). As more and more art therapists work in the schools, the resources have grown and will no doubt continue to do so (Frostig & Essex, 1998; Moriya, 2000; Stepney, 2001). On the **DVD** you can see individual work in a school by Janet Bush **(J)** and an art therapy class with Alice Karamanol **(K)**.

Art as Therapy for Normal Adults

Art can be therapeutic for normal individuals of all ages, not just school children. Sunday painters from Winston Churchill to Judy Collins have found making art to be immensely helpful, especially during periods of stress—like the kind Churchill was under during World War II.

Art classes—taught by clinically sensitive teachers or art therapists—can also be therapeutic, like Schaeffer-Simmern's (1961) work with *persons in business and the professions,* or that of Florence Cane, who released the creativity of many adults in her New York studios **(L)**. In 1972, Elinor Ulman described the therapeutic value of *art classes* for the normal adults she taught at a museum in the *Journal of the American Association for University Women*. Art therapist Robert Ault opened an art school after 18 years at Menninger's. In *Art Therapy with the Unidentified Patient* (Wadeson, Durkin, & Perach, 1989), Ault detailed the therapeutic benefits of learning art for students of all ages **(M)**.

Creative art activities can also be therapeutic for normal adults when they are used in *sensitivity, encounter*, or *human potential groups*, as in Janie Rhyne's **(N)** work at the Esalen Institute (1995). "Growth centers," like Omega, continue to offer many workshops using art for self-development. The number of books offering guidance to those wanting to liberate themselves through creating has grown as well, with art therapists as well as artists (Cameron, 2002) among the authors (Allen, 1995, 2005; Malchiodi, 2002, 2007; McNiff, 1998b).

Art therapists working in a variety of settings have sometimes used their understanding of art and group dynamics for *staȧ development.* Art exercises can be helpful in looking at both individual and interpersonal dynamics—as applicable to a staff group as to a family. Such workshops help employees to function more effectively in the work place, since art is a dramatic tool for clarifying interpersonal issues.

Robert Ault, who did this kind of work through the Menninger Foundation, continued it as a *business consultant* after his retirement from the clinic. Another role for an art therapist in the business world is in *Employee Assistance Programs* (EAP). As in other non-psychiatric settings—like medical hospitals or schools—art is an efficient tool for the screening, which is a major part of the job of an EAP counselor.

Concluding Thoughts

Art therapy, then, is extremely useful in both primary and secondary prevention—not only in treating people who have ended up in psychiatric settings. As mental hospitals close (*deinstitutionalization*) and patients with chronic disorders go elsewhere—like group homes and recreation or rehabilitation programs—art therapy is often an available source of support.

If such people get lost in the shuffle, they may end up in shelters or even prisons, where they may also be helped by art therapy.

People in all kinds of crises—personal, medical, social, economic—can be helped to master them through art therapy. And normal people of all ages dealing with the ups and downs of everyday life can be helped to cope and to grow through the therapeutic use of art. Making art provides practice in creative problem solving, useful in all aspects of living. It also helps people to articulate a clearer sense of themselves, through their own unique creations. These preventive roles for art therapy have led to an expansion of the field, well beyond its original role in mental hospitals and clinics. Art therapists are therefore finding themselves in new places, sometimes with new people and purposes as well.

Art therapists in different places work at different tempos, depending on the nature of the setting. Art therapists also enter people's lives at different points in the process of growing or coping with stress. Sometimes the art therapist's involvement with those she serves is brief, as in a shelter or an emergency room. Sometimes the art therapist's involvement is sustained, as in a prison or a school. Whether short or long and whether the tempo is rapid or slow, art therapy can facilitate screening, coping, working through, healing, even dying.

Endnotes

1. "An Art Therapy Protocol for the Medical Trauma Setting," by V. E. Appleton, 1993, *Art Therapy, 10*(2), 71.
2. "Spontaneous Artwork as an Aid in Self-Rehabilitation: The Case of a Temporarily Handicapped Boy," by J. H. Schwarz, 1985, *Art Psychotherapy, 12*, 81–87.
3. "The Potential of Rehabilitative Computer Art Therapy for the Quadriplegic, Cerebral Vascular Accident, and Brain Trauma Patient," by D. J. Weinberg, 1985, *Art Therapy, 2*, 86.
4. Simon, R. M. (1982). "Peter: A Severely Disabled Patient's Triumph Through Art, by R. M. Simon, 1982, *American Journal of Art Therapy, 22*, 13–15.
5. *Psychoneuroimmunology*, 4th ed., edited by R. E. Adler, 2007, New York: Academic Press.
6. "Art Therapy Reduces Pain and Anxiety in Cancer Patients," by N. Nainis & J. Paice, 2006, *Journal of Pain & Symptom Management.*
7. "A Randomized, Controlled Trial of Mindfulness-Based Art Therapy (MBAT) for Women With Cancer, 2005, *Psycho-Oncology, 15*(5), 363–373.
8. "Art Therapy With Pediatric Cancer Patients," by T. Councill, 1993, *Art Therapy*, 78.
9. "Children of the Stones: Art Therapy Interventions on the West Bank," by J. G. Byers, 1996, *Art Therapy, 13*(4).
10. "Colors of Disaster: The Psychology of the 'Black Sun,'" by V. Gregorian, A. Azarian, M. DeMaria, & L. McDonald, 1996, *Art Psychotherapy, 23*(1), 1–14.
11. Klingman, A., Koenigsfeld, E. & Markman, D. (1987). "Art Activity With Children Following Disaster, by A. Kingman, E. Koenigsfeld, & D. Markham, 1987, *Art Psychotherapy, 14*(2), 153–166.
12. "Art Therapy With a Community of Survivors," by J. G. Jones, 1997, *Art Therapy, 14*, 89.
13. *Children of Cardozo … Tell It Like It Is*, 1968, Cambridge, MA: Education Development Center.
14. Timm-Bottos, J. (1995). "ArtStreet: Joining Community Through Art, *Art Therapy, 12*(3).

CHAPTER 11

Professional Issues

Thus, the art therapist combines several disciplines. [S]he is at once artist, therapist, and teacher. To maintain a sound balance between [her] several functions is [her] greatest skill.

Edith Kramer

Evolution of Art Therapy Education

This chapter describes the development of educational programs in art therapy, the training required to be a competent art therapist, and some of the unique aspects of learning in this field. It is also about the evolution of standards for educational programs and for practice, as well as the development of art therapy in regard to public and professional awareness. Although the discipline is still quite young, it can fairly be said to have come of age in many of those areas distinguishing the professions.

In order to promote art therapy education, the American Art Therapy Association (AATA), founded in 1969, first needed to define a competent practitioner, and then to articulate guidelines for training. The development of standards for both individuals and training programs is described below. In order to understand how art therapy education has evolved, I will first review some of the many paths people have taken.

Becoming an Art Therapist

Learning by Doing

Most first-generation pioneers were truly self-taught, including Edith Kramer and Margaret Naumburg, each inventing her theories of art therapy from her own learning and experience. Also self-educated were artists like Edward Adamson in England and Mary Huntoon in America, both of whom worked with patients in an intuitive fashion. The guidance they received from the psychiatrists who initiated and supported their presence was usually to do what came naturally.

The idea in most settings where art was offered to mental patients was to make available the healing properties of the creative process itself. From the outset, there was a fear

of compromising the therapeutic potential of art by "psychologizing" it, recently reflected in a concern in the United States about the "clinification" of art therapy (Allen, 1995) and a return to the studio (C. Moon, 2002).

Since my undergraduate work was in art and my master's in education, when asked to work with hospitalized schizophrenic children, I wanted very much to pursue further study so I could do a better job in my clinical work. After presenting my work with a child who had expressed herself powerfully in art (Dorothy in Chapter 9, **DVD 9.3**) to visiting consultant Erik Erikson at a Grand Rounds, I asked his advice about what to study. Though I now disagree, he urged me to do nothing, feeling that it might interfere with the success of the intuitive approach I was forced, by default, to follow.

So, like many before there were training programs, I learned by reading, by consulting with the two authors with whom I corresponded (Naumburg and Kramer), from the work I was doing with the children, and from collaborating with others on the unit.

Learning by Teaching and Consulting

There is no question that informing others, whether through presenting a case, being on a public television program (as the Art Lady on *Mister Rogers' Neighborhood* from 1966 through 1969), teaching art education courses at a local college, and writing articles (which I began in 1969 for an art education journal and for a local preschool newsletter), is a useful way to learn. Because art therapy was so young and as yet unformed, I had to organize the information I was reading and gathering for myself as well as for others.

Like many others, I also learned a great deal by developing programs in a variety of settings. In 1967, I was invited to be a consultant and to start an art department at a residential institution for youngsters with physical disabilities, the Home for Crippled Children. When I first met with the administrators, I was shocked by how few children they thought would be able to participate.

The program itself was modeled on my partly digested understanding of the ideas of therapeutic art educators (Lowenfeld, 1957; Cane, 1951), but I was probably most influenced by the program Edith Kramer had initiated at the Wiltwyck School for Boys, which she described in *Art Therapy in a Children's Community* (Kramer, 1958).

Thanks to my experience at the hospital, I was able to design a rudimentary assessment to determine who might benefit from art. As I suspected, everyone was capable of doing something, though some required creative adaptations. It confirmed a study about the powerful effect of adult expectations on children's performance (Rosenthal & Jacobson, 1968), and I am now certain that art therapists' expectation that everyone can create is a major reason for our success. The following vignette about Claire, while dramatic, was not so unusual.

Art Reveals Capacities of a Deaf-Mute Girl: CLAIRE (10)

Claire had just come back from the dentist. Inside she was screaming with the agony of the encounter, but she had no words, not even gestures, with which to express the impact of this traumatic experience, for Claire was a deaf-mute, crippled and in a wheelchair. Before she drew her first picture, she had been withdrawn from school and speech therapy, since the staff was convinced that she was profoundly retarded.

As it happened, Claire's art evaluation was scheduled right after a visit to the dentist **(DVD 11.1)**. She wheeled herself up to the table, grabbed a marker and paper, and drew a picture which—more eloquently than any words—told what it feels like to be invaded by the dentist's tools, to be open and vulnerable and terrified **(A)**. Though helpless, like any patient

Figure 11.1 Drawing after a dental visit.

in a dentist's chair, Claire could master the traumatic event by expressing her feelings in art, effectively turning passive into active (**Figure 11.1**).

More important for her future, the age-appropriate drawing revealed that Claire's intelligence was much higher than anyone had imagined **(B)**. She was again placed in a classroom and resumed language therapy. In both settings, she used a Talking Book to communicate with others (**Figure 11.2**). The pictures were drawn by Claire and then labeled by the teacher or speech therapist, as in her picture of the doctor and the nurse **(C)**.

Learning by Sharing with Others

In 1967, I heard about a child psychiatrist named Marvin Shapiro who was interested in the arts therapies, and in 1968 I went to see him. He invited me to join a weekly expressive arts study group he had recently started at the Pittsburgh Child Guidance Center (PCGC), the outpatient teaching clinic of the Department of Child Psychiatry. The chairman offered me the opportunity to start a pilot program at PCGC that was to be a one-day-a-week "trial" (his word) of art therapy in that setting.

Learning in Personal Psychotherapy and Supervision

Having consulted with both pioneers in the early 1960s, I again sought the advice of Margaret Naumburg and Edith Kramer. They were very generous with their time—meeting with me, allowing me to visit their classes, and because Kramer was working at the Jewish Guild for the Blind and Jacobi Hospital, I was also able to observe her conducting art therapy sessions. Their ideas about art therapy were different, but their advice about learning to be a good clinician was not. Each, independently, said there were two key things I needed to do if I was going to become an art therapist. One was to engage in my own psychotherapy, which I had already initiated in 1967. The other was to be supervised by an experienced clinician.

Both pioneers said that a supervisor's professional discipline mattered less than their respectful support of art therapy. I was fortunate to have an enthusiastic mentor in Marvin

Figure 11.2 A picture from Claire's talking book.

Shapiro (**Figure 11.3**). By this time, most psychiatrists and psychologists who facilitated the hiring of art therapists trained them too, as in my case. The supervision was frequent and intensive. Dr. Shapiro, who was also a child analyst, observed art therapy sessions through a one-way observation window. We also met for two hours every week.

Both of us were keenly aware that art therapy was "on trial" at PCGC. We needed to prove—to those in the established disciplines of psychiatry, psychology, and social work—that art therapy could offer something unique. Most early art therapists were required to demonstrate the value of this unfamiliar discipline to those in charge. This is still true whenever art therapy is new to any setting. Although such pressure is stressful, it is also a

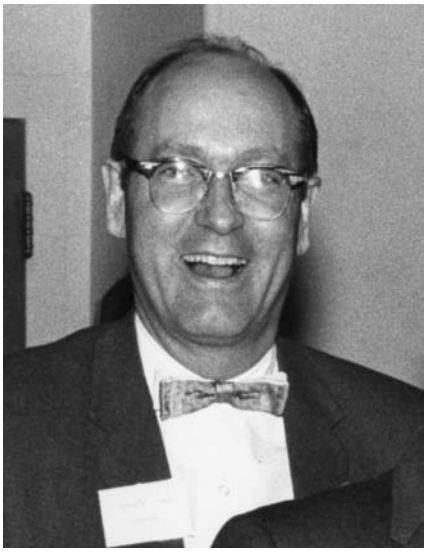

Figure 11.3 Marvin Shapiro, MD, my mentor.

Figure 11.4 A seminar at Margaret Naumburg's.

powerful stimulus for creative problem solving, as well as for research, critical thinking, and articulating our ideas more clearly.

Apprenticeships, Courses, and Training Programs

Like artists through the ages, some who were in a setting that already had an art therapist had an apprenticeship. At first, these were individualized situations, like Don Jones training Bob Ault at Menninger's, or Hanna Kwiatkowska training Harriet Wadeson at the National Institute of Mental Health (NIMH) (Junge & Wadeson, 2007). Just as early individual courses like the seminars in Margaret Naumburg's apartment **(Figure 11.4)** and at different schools were the precursors of organized training programs, so these apprenticeships foreshadowed the development of formal clinical practicum and internship as part of art therapy training.

Like the profession itself, art therapy education had a long incubation period prior to one of rapid growth. Although isolated courses and some certificate training programs began earlier, the formation of the American Art Therapy Association in 1969 was a tremendous impetus to the development of formal training. The graduate schools initially offered one-year programs, but within a short time all added a second year of full-time training. By 2009, there were more than 40 master's degree programs, over 30 of which had been awarded approval by AATA (www.arttherapy.org).

After intense debate within AATA about the adequacy of undergraduate preparation, the master's degree was ultimately recognized as the entry level for the practice of the profession. Clinical internships, once an alternative route to credentialing, are no longer available, although their essence—training by observing, assisting, and being supervised by an art therapist—remains a central part of art therapy education. Undergraduate programs in existence are viewed as preparation for graduate work.

Because art therapy is such an interdisciplinary field, training programs have always been housed in a variety of schools and departments, which affects their student body and

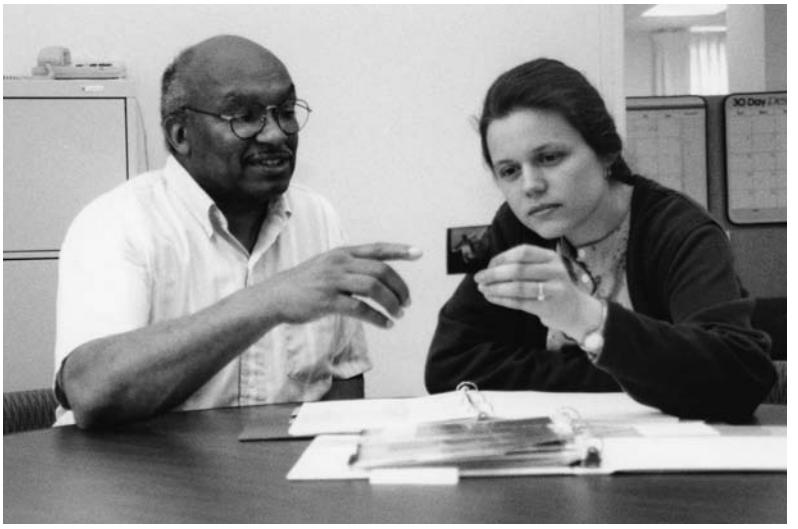

Figure 11.5 Charles Anderson doing supervision.

character. For example, the program at the Art Institute of Chicago tends to attract those who are more interested in the artist part of being an art therapist (C. Moon, 2002), while the program at Eastern Virginia Medical School has a more clinical emphasis. Because of the development of standards for practice and training, all programs are now required to have the same prerequisites and to offer courses in the same areas (www.arttherapy.org).

Supervision

Supervision is the most vital and delicate aspect of clinical training in any therapy, including art therapy. It has only been discussed rather recently in the art therapy literature (Lahad, 2000; Malchiodi & Riley, 1996; Schaverien & Case, 2007). As is true in art therapy education, art itself (both that produced by the client as well as the supervisee) is an important element of the process. The many creative possibilities for the use of art activities in relation to clinical work are limited only by the imagination of the supervisor (**Figure 11.5)**.

Self-Awareness

The need for students to grow in *self-awareness* seems to be one on which all art therapy educators agree. Some insist that only *therapy* will do it; others feel that self-inquiry need not take that form. For myself, I think Naumburg and Kramer were right to recommend that I become a patient in psychotherapy. I have often wondered if being an *art therapy* patient would have been an even more useful learning experience. It is my belief that *personal psychotherapy* is an essential part of a full educational experience for all therapists, including art therapists.

The work is so intense, and in some ways so intimate, that blindness about unresolved personal issues is a real danger. It is easy to rationalize one's responses, and the only antidote to acting out on the part of the therapist is self-knowledge. Even after years of therapy, experienced clinicians often seek consultation or even treatment in regard to difficult cases.

Being an art therapist is not easy, and wishful fantasies of rescue and repair are soon replaced by a need to accept the inevitable frustrations and failures of the work. Like all

clinicians, art therapists need to face their "dark side"—the rejected parts of themselves. Therapists cannot help patients to deal with their "shadows" if they have not made peace with their own. Experienced workers know about the powerful effect on the art therapist of confronting her own "dark side" as well as the patient's.

Art therapists also need to deal with their grandiosity and their own inevitable narcissistic reactions to idealization, as well as to devaluation. Art therapy, like any other kind of psychotherapy, can be stressful. Making art is a fine way to reflect on a difficult session, patient, or colleague.

Images of Supervision

As a supervisor, when frustrated by my inability to communicate with a blocked supervisee, I would sometimes imagine a sow's ear actually turning into a silk purse. Happily, helping most neophytes to become good therapists does not require such an impossible transformation. My own favorite metaphor for the hazardous shoals of supervision is a book from my childhood, *Epaminondas and His Auntie*. It is a tale about how foolish it is to apply suggestions that are appropriate for one situation to another one where they don't fit. Here is the gist of the story …

Epaminondas went to see his auntie every day, and she always gave him something to take home to his mother. The first was a big piece of cake, which the boy put in his fist "all scrunched up tight," and "by the time he got home there wasn't anything left but a fistful of crumbs."

After his mother yelled at him for being so foolish, she told him that "the way to carry cake is to wrap it all up nice in some leaves and put it in your hat." So when his auntie next gave him a pound of butter, Epaminondas wrapped it in leaves, put it in his hat, and put his hat on his head. Since it was a very hot day, the butter melted. His mother again gave Epaminondas advice about how he should have wrapped and carried the butter. As you might imagine, that is how he handled the puppy dog he got the following day, with equally sad results.

The message of the book is relevant for any supervision that suggests what *could or should have been done* at any particular clinical moment. Most supervisors do not give direct advice, preferring to explore the situation in question with the trainee. It is clear that learning how to *figure out* good answers is much more useful than *knowing* any number of them. The wish to have a "recipe book" or a "script" is understandable, and is even common among the creative people who become art therapists. Fortunately, there are some art therapists who genuinely enjoy supervision, like Arthur Robbins (**Figure 11.6**), who has conducted regular supervision groups for many years (Robbins, 1988, 1997).

Promoting Creativity in the Art Therapist

The *creativity* of the therapist is critical to any effective therapy, including art. Many have been concerned about "the search for the formula" among art therapists, and have suggested that a clinician needs to be able to use her artist self in a flexible, yet disciplined way. But promoting inventiveness in the context of self-discipline is far from simple.

In fact, the notion of *creativity* is almost as slippery as catching fish with your bare hands. In a satire on education, *The Saber-Tooth Curriculum* (Benjamin, 1939), about a stone-age experimental institution called the School of Creative Fish Grabbing, the dean of Teachers' College wrote: " The creative part is the heart of the whole movement—just to catch fish—That's nothing—but to grab fish *creatively*—Ah! That is something!" Happily, despite the

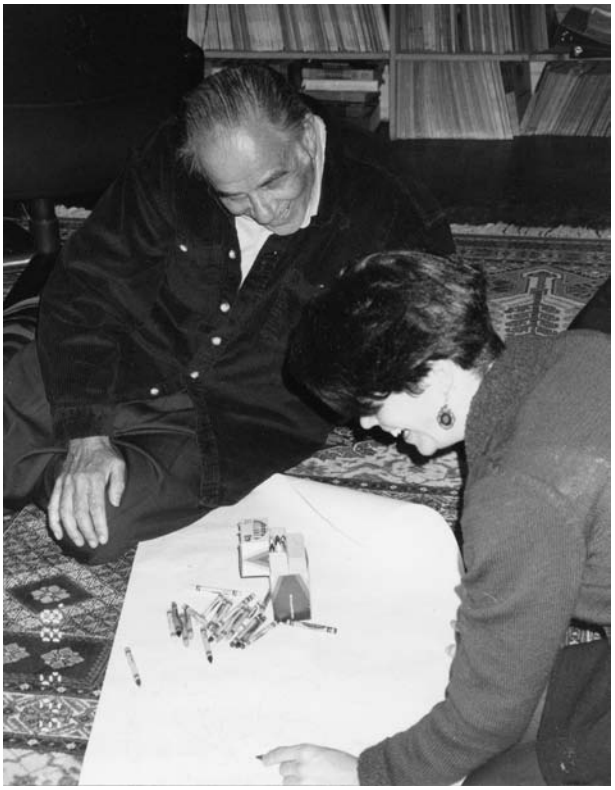

Figure 11.6 Arthur Robbins supervising a student.

complexities and challenges of the work, doing art therapy is much more creative and infinitely more satisfying than grabbing fish.

Becoming an Art Therapist: Professional Identity Formation

Making the transition from training to practice can be hard. One recent graduate dealt with her frustrations by writing a book (Makin, 1994), and another experienced clinician offered advice to beginners (Schroder, 2005). It is fortunate, despite the cost and time involved, that postgraduate supervision is required for registration, because it is essential to growing as a therapist.

The support and feedback of a study or peer supervision group with other [art] therapists can also be immensely helpful. For example, when dealing with severely abused clients, all therapists are at risk for "vicarious traumatization," and boundary violations are both tempting and confusing.

Establishing and consolidating a professional identity takes time in any profession. It may be especially difficult in art therapy, because of the inevitable tug of war between the clinician's artist-self and therapist-self. Even if the issue of their relative importance in one's clinical work has been settled, there is still the pragmatic problem of finding the time and energy to make art.

This has been a source of discontent, personally as well as philosophically, from the inception of the field. Robert Ault, art therapist at the Menninger Foundation who had continued to do his own painting, put it quite simply in a talk in 1976 (AATA *Conference Proceedings).*

He had been asked: "If someone shook you awake at 3:00 in the morning and asked 'Are you an artist or a therapist?' how would you answer?" Bob then said that he had found himself deciding in favor of "artist," but that he also resented having to make a choice.

Mildred Lachman-Chapin (1994), who often addressed the question, was instrumental in the formation of an *Art Committee* within AATA. Art therapy students whose training programs are in art schools, however, are sometimes seen as "second-class artists." And in treatment settings, because of their low position in the hierarchy, art therapists often feel like "second-class therapists." In fact, one prominent drama therapist identified a "shame dynamic" in the expressive arts therapies (Johnson, 1999).

Evolution of Standards

It may come as a surprise that the desirability of a national art therapy association in America was hotly debated before it was formed, and that the debates were due primarily to concerns about excellence. The pioneers whose writings had defined the profession in the United States were scholarly individuals with high standards. They feared that their devotion to quality might be weakened, and the worth of their creation cheapened. Forming an organization in 1969 necessarily included people with widely varying educational and experiential backgrounds, and equally varied ideas about qualifications.

Art therapy has, however, benefited greatly from AATA's birth. Only a national professional association could define and enforce standards for individuals, for training programs, and for practice. As a result, art therapy has come of age as a responsible profession, well respected by other disciplines and by the public. That would not have happened without defining excellence in all these areas, as well as creating mechanisms for certifying its presence. Current requirements for credentials and for training programs are found on the AATA website (www.arttherapy.org). A bit of history is included because I have discovered in recent travels that some of the steps we took along the way provide useful models for other countries where art therapy is beginning to organize.

Standards for Registration

There were heated disputes at the first meeting of AATA about the desirability of any codified standards. Pioneer art therapists, all of whom had creatively defined their own work, feared that specific requirements for practitioners might choke the growth of the new field. In a very close vote, the decision was made to define some people as "registered," in order to differentiate those who were qualified from those who were not. *Registered Art Therapist* was and still is designated by the letters ATR. As is usual when a profession establishes a credential, a *grandfather clause* was adopted for those with five years of experience.

One of the first and most difficult tasks, after agreeing to credentialing, was to define standards, since it was quite a challenge to assess competence in a discipline with hardly any formal training, and widely different kinds of preparation among practitioners.

The solution to the problem of setting fair and flexible standards was solved by Sandra Kagin Graves, who came up with the notion of Professional Quality Credits (PQCs). In this system, points could be earned for a variety of preparatory learning experiences, including apprenticeships, courses, and publications. A minimum of 1000 hours of supervised work was the only non-negotiable requirement. Each applicant had to demonstrate that her experiences qualified her for a total of 12 PQCs, which would enable her to be a Registered Art Therapist (ATR).

Over time, the criteria for registration have been modified, due to the increased availability of formal education, and the decision that the master's degree be the entry level for the profession. Registration, originally handled by the Standards Committee of AATA, is now administered by a separate entity, the Art Therapy Credentials Board (ATCB). A combination of master's-level education and 1000 to 1500 hours of postmaster's supervised clinical experience is currently required to become an ATR (www.atcb.org).

Standards for Board Certification

In 1994, also after much debate, a written Certification Examination was developed, designed to identify a higher level of proficiency than the entry level of registration. Passing this exam entitles the art therapist to identify herself as Board Certified (ATR-BC). In order to maintain board certification, each individual is required to accumulate 100 Continuing Education Credits (CECs) every five years.

Credentialing mechanisms in all human service professions exist primarily to protect the public from incompetent practitioners. Like *licensure,* which is now available to art therapists in many states because of successful lobbying efforts, registration and certification are ways of identifying qualified clinicians.

Standards for Educational Programs

A quandary similar to the one about registration standards faced early AATA boards as they tried to establish criteria for educational programs. Wishing to preserve the range of orientations in art therapy, and wanting program standards to be at least as flexible as those for registration, AATA published *Guidelines* for Academic, Institute & Clinical Art Therapy Training, now called *Education Standards* (www.arttherapy.org).

The document is clear about the fundamental courses and clinical work essential to learning art therapy, but allows for a variety of interpretations on the part of specific training programs. There are specific requirements for postmaster's degree programs (for clinicians from other fields) and a list of both undergraduate and graduate training programs can be found on the AATA website (www.arttherapy.org).

The *Educational Program Approval Board* (EPAB), developed in 1978, was originally called the Education & Training Board (ETB). Its task is to assess the quality of educational programs, to designate those qualifying for approval, and to periodically review approved programs. As of March 2009, 33 of the programs on the list had met the criteria for approval.

Students graduating from an approved program are required to have 1000 postgraduate hours of supervised clinical work in order to be eligible for registration. Those graduating from programs that have not been approved are required to accumulate 1500 hours of supervised work. Currently, programs meet annually before the conference in the *Coalition of Art Therapy Educators* (CATE), a tradition that was initiated in 1978 by Sandra Kagin Graves.

Evolution of Continuing Education

Learning Through Further Education

Even before Continuing Education Credits were required to maintain board certification (1994), there had been a growing interest among practitioners in expanding their skills and knowledge. Since 1982, pre and post conference mini-courses have been offered by AATA, with CECs available. Since 1988, regional symposia have been organized by AATA, and are available at no charge to the sponsoring local chapter.

My own story, the beginnings of which were described earlier, is relevant here. Erik Erikson had indeed succeeded in discouraging me from seeking further training in 1964. Working at PCGC in January of 1969, I was soon supervised on a regular basis not only by Dr. Shapiro, but also by two other experienced child psychiatrists. I was learning by collaborating with colleagues and from in-service training, but it wasn't enough.

Fortunately, my primary supervisor (Shapiro) was as *encouraging* as Erikson had been *discouraging.* By then I had spent several years in the individual psychotherapy recommended by both Naumburg and Kramer, and I was being supervised by experienced clinicians, as they had also suggested. Unlike my earlier adjunctive work in the hospital, this therapy was outpatient, and I often became the primary therapist for nonverbal youngsters. I therefore felt an even greater responsibility to deepen my rudimentary clinical skills and understandings.

After investigating the psychology doctoral program and finding it to be heavily experimental, I decided to study psychoanalysis at the local institute because my best supervisors and teachers had been analysts. Halfway through my training analysis, I discovered that my feeling that I didn't *need* a PhD had neurotic roots, and realized that I was denying the realistic benefits of having a doctorate.

I was fortunate to find a doctoral program where I was able to get credit for my master's degree and for courses at the Pittsburgh Psychoanalytic Institute. I met the dissertation requirement by writing a book about art therapy with children (Rubin, 1978). One of the reasons the proposal was approved was that in 1975 it was easy to demonstrate the need for more art therapy literature, since there were very few books by art therapists.

The doctorate required that I become competent in six areas: research, consultation, supervision, systems theory, group dynamics, and theories of psychotherapy other than Freud. The psychoanalytic training required that I conduct six supervised analyses (three adults and three children), attend courses, and complete the required personal analysis. That training took ten years, while the PhD took two.

Weekly microscopic supervision using detailed process notes was one of the most helpful aspects. The tripartite integration of theory and practice with my analysis was a wonderful way to learn. It also validated the requirements that were developing for art therapy training: a combination of didactic instruction and supervised clinical work.

Obtaining Relevant Credentials

The most useful fringe benefit for me of obtaining the doctorate had not even been a goal when I went back to school. But what turned out to be most practical was being able to qualify after two more years of practice to sit for the psychology licensing exam.

When I left the university in 1985 for private practice, it was extremely helpful to have the license, a credential respected by most insurance companies, who would reimburse the patient for all or part of the cost of therapy. Having a credential that is recognized by others eventually became a need for art therapists. It is for this reason that AATA educational requirements now include counseling courses, since that field is licensed in almost every state.

Ethics in Art Therapy

Standards of Practice and Ethical Conduct

Most professions establish standards for practitioners, including those already credentialed. Like assessing competence and reviewing the quality of training programs, maintaining ethical standards is the responsibility of a mature professional organization. The latest

Ethical Principles for Art Therapists are available through the AATA website (www.arttherapy.org). If someone is thought to be behaving in an unethical fashion as a professional, charges may be filed with the association's *Ethics Committee*.

In human beings, the *superego* or *conscience* is the part of the personality that typically feels guilt. It is also the part that invokes or seeks punishment for thoughts or actions perceived as "bad." There is also another part of the superego known as the *ego ideal,* which establishes goals, aspirations, and approval for thoughts or actions seen as "good." If the superego is the part that spanks (punishes) people, the ego ideal would be the part that applauds (rewards) people. While disapproval is meted out by the Ethics Committee in AATA, rewards are given by the Honors Committee.

The association's highest honor is the Honorary Life Membership (HLM), recommended by the Honors Committee and approved by voting members. It recognizes art therapists who have made significant contributions to the organization and to the profession. The Distinguished Service Award (DSA) is given to individuals who have done especially important work for the association.

The Clinician Award is given to those who have done outstanding clinical work in some specialty. There is also a Government Affairs Award honoring Nancy Schoebel, a Film Award honoring James Consoli (1993), and the Rudolf Arnheim Award for non-art therapists who have contributed to the profession. In addition, there are a variety of special awards for meritorious service in a specific area, as well as various funded awards for scholarships, research, and writing.

Being a human service professional, whether in private practice or under an institutional umbrella, requires strict adherence to such principles as maintaining the patient's privacy, and the clarity of both roles and boundaries. Artists, however, have few such concerns. In fact, since they exhibit publicly, they actively invite people into their worlds. Nevertheless, it should be possible to expand art therapy's horizons—as in an open studio—without abandoning our responsibility to those we serve.

The fundamental underpinning of any system of ethical conduct is *respect* for those involved. If there is sincere respect for the other, then ethical guidelines flow naturally. This is true whether we are talking about respecting an individual's *artwork, imagery,* or *personal boundaries.* Respect also means not taking advantage in any way of the *power* of the special relationship a clinician has with patients in therapy. This is true for all who are in a position of power over others, including supervisors, teachers, doctors, clergy, friends, and parents.

Responsible art therapists are knowledgeable about *legal and ethical issues,* especially when they are in *private practice.* A primary concern of those who protect the public through licensure is assuring that the professional is accurately representing her qualifications. Even though I, for example, have been licensed to practice as a psychologist in the state of Pennsylvania since 1979, I would not dream of doing things for which I am not trained, such as psychological testing or hypnosis. Admitting that one is floundering is also a matter of ethical responsibility, as is seeking more experienced and objective consultation.

Ethics and the Art Created in Art Therapy

Provocative Images There are some ethical concerns that are peculiar to art therapy, such as the issue of what to do about *violent or provocative images* in group situations, whether they occur in treatment or in training. While this isn't covered in AATA's *Ethical Principles for Art Therapists,* it is an issue with which all therapists must deal.

Ownership and Storage Although *institutions* sometimes view patient art as a part of the clinical or educational *record,* most art therapists feel that the art ultimately *belongs to the artist.* Many of us encourage patients to store artwork in the therapy space if at all possible during treatment, since it offers a marvelous opportunity to reflect on the progress of the therapy. While potentially useful at any point in time, such a visual review is especially worthwhile as part of the termination process. On the **DVD (11.2)**, you can see Mala Betensky reviewing and comparing art with an adolescent in the course of their therapeutic work.

Confidentiality and Exhibitions Because patient art cannot only be displayed in its original state, but can also be reproduced as photographs or slides, guidelines have been developed for this delicate area of confidentiality and are part of the *Ethical Principles for Art Therapists*. Spaniol, who has been concerned about the possible use of artwork without explicit consent by "outsider artists," has proposed respectful agreement forms, ways of writing about and displaying client art, and has written a manual on organizing such shows (Spaniol, 1990).

Over the years, I have participated in a variety of public activities involving art by patients with mental illness and retardation. They have been in connection with many types of settings, from inpatient units to partial hospitals to museums, and have included competitions and exhibitions for which I have served as a judge. It seems to me that, as with our overall stance in relation to our clients, the notion of *respect* offers an appropriate guiding principle for assessing what is best in each instance.

When it is possible to bring admiration and sometimes income to individuals through their art, exhibiting their products can be a wonderful experience, as long as they are in full agreement. It is a bonus beyond the intrinsic pleasures and therapeutic benefit of involvement in creative activity. When we are also able to use such expressions of the human spirit to educate the public and to demystify the myths about mental illness, it seems to me to be a marvelous message for our medium. The key to doing it ethically is respecting the artists whose work is involved.

Ethics and Client/Therapist Differences

Disability Issues

Although respect is essential when doing art therapy with anyone in any setting, it may be more difficult to achieve when the client is radically different in some way that might not be fully grasped by the therapist. The difference might be the particular disorder or disability from which the person suffers. David Henley has pointed out ethical considerations, for example, in the use of art for assessment with those who are physically or mentally handicapped.[1]

The *otherness* of the disabled person's experience is difficult but vital for any therapist to comprehend. It can affect how the individual experiences the world and art as well, both when responding and while creating with materials. Just as it is crucial for art therapists to know developmental issues when working with people at different stages of growth, so it is necessary to try to apprehend, as much as possible, the different person's way of being-in-the-world.

For example, Viktor Lowenfeld noticed that some partially sighted and blind children used their sense of touch and kinesthesis more to "see" the world, whereas others relied more on their limited vision. He named the two types of perception *haptic* and *visual*. In experiments with sighted individuals, he concluded that the two perceptual types were also

present in those with vision, to varying degrees. These differences would affect how the worker would motivate and guide their art making. I made a similar discovery while working with blind children, of what I called a *tactile aesthetic*, which turned out to be different from a visual one. Here is a brief description of a research study my colleagues and I conducted in order to better understand this phenomenon.

Phenomenological Research on a Tactile Aesthetic

Judges who were blind, partially sighted, and sighted were asked to choose their most favorite and least-liked object from a group of wood-scrap sculptures—with equal numbers of sculptures made by all three populations (**DVD 11.3**). Our hypothesis was that the children would *prefer artwork done by someone like themselves,* whether they had useful vision (sighted and partially sighted) or were blind.

We found that artwork preferred by visually impaired **(Figure 11.7)** or blindfolded youngsters **(Figure 11.8)** differed significantly from what was preferred by children using whatever sight was available to them **(Figure 11.9)**. And it was confirmed at a *statistically significant* level.

We also found *qualitative* similarities and differences in the judges' verbal and tactile responses to the sculptures, unrelated to their choices. Most of the youngsters liked sculptures with some variety and a sense of order. The visually impaired tended to label objects as representational, while the sighted were able to be interested in abstract work. The blind children also reacted more strongly to certain structural features—particularly projections, which they disliked, and holes or enclosures, which they liked.

While the sighted judges tended to be fairly objective in their responses, the blind youngsters were more subjective, often relating things to themselves, reacting with anxiety to anything perceived as dangerous or unstable. A girl preferred one sculpture to another, for example, "because it won't get knocked over as easy as this one. Things make me nervous that can fall over easily." Our work with these blind artists was significantly enhanced by gaining a better understanding of how their aesthetic responses were different from our own.

Figure 11.7 A blind girl examines a wood sculpture.

Figure 11.8 A blindfolded girl compares two sculptures.

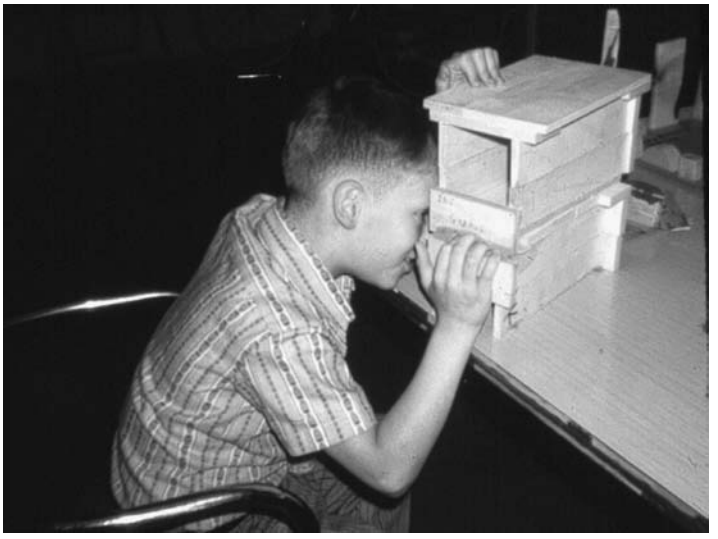

Figure 11.9 A partially sighted boy explores a sculpture.

Multicultural Issues

Just as art therapists monitor their preconceptions about those with disabilities, so too are they attuned to their attitudes toward the different cultures from which their clients come. Respect for the values and traditions of the other is the key to multicultural sensitivity, including the culture's aesthetic. Such considerations are essential when we serve clients whose background is radically different from our own **(DVD 11.4)**.

This issue has been of particular concern in the United States, because of the many people of color who live and work here, who are sometimes referred for art therapy—and the very small number of mental health professionals who come from the same cultural milieu.

Figure 11.10 Cliff Joseph, Art Therapy & the Third World

While the number of art therapists of color is steadily increasing, there is a tremendous need to raise the consciousness of those art therapists who daily serve Black, Hispanic, Asian, and Native American clients.

In the beginning, the American Art Therapy Association had very few members of color, despite the presence of individuals like Christine Wang **(A)** and Lucille Venture **(B)**, whose doctoral dissertation (1977) was entitled *The Black Beat in Art Therapy Experiences*. In 1974 Cliff Joseph **(C)** **(Figure 11.10)** convened a panel on *Art Therapy and the Third World* **(D)**, which included pioneers like Lemuel Joyner from New York and Georgette Powell **(E)** from Washington, founder of one of the first community-based art therapy programs, Tomorrow's World **(Figure 11.11)**.

For many years, Charles Anderson (**F**) of Menninger's led what was then known as the Third World Committee. The committee sponsored a number of consciousness-raising events, such as a panel titled "Cultural Awareness & the Creative Process" at the 1981 conference, chaired by Sarah McGee (**G**).

The group has been revitalized by the presence of a new generation, people like Gwen McPhaul Short (**H**), Anna Hiscox (**I**) (Hiscox & Calisch, 1997; Virshup, 1993), Cheryl Doby-Copeland (**J**), Charlotte Boston (**K**), and Stella Stepney (**L**).

First named the Mosaic Committee, it is now called the *Multicultural Committee* (MCC). The committee has succeeded in having a course on multicultural competence included in AATA's requirements for educational programs, and in adding that topic to AATA's ethics document. Members are working on a number of projects, including the creation of a film using interviews of pioneers, provisionally entitled "In Living Color."

> The Multicultural Committee (MCC) works to increase the social responsibility, awareness, knowledge, theories, and skills of art therapists to effectively work with people of multiple cultures, ethnicity, and racial background, of multiple religions, ability, age, sexual orientation, gender, socioeconomic levels, nationality, and indigenous heritage.

Figure 11.11 Georgette Powell teaching in a library.

> The purpose of the committee is to provide information, networking, and mentoring for all art therapists to develop their cultural competence and to increase the diversity and pluralism within the AATA membership.[2]

Many art therapists, especially those who have taught in different parts of the world, have discussed cross-cultural considerations. Landgarten's *Magazine Photo Collage* (1993) is subtitled *A Multicultural Assessment & Treatment Technique*. Like the primers for beginning readers that finally included pictures of people of color as well as whites, the technique allows the minority patient to find images with which he can identify. The book also has case material on assessment and therapy with Asian, Black, and Hispanic clients, filling a previously unmet need (Cf. Coleman & Farris-Dufrene, 1996).

The 1996 AATA Conference focused on multicultural issues, with many presentations that helped to sensitize the largely white, female, middle-class members of the organization. Even though artists as a group tend to be color-blind, there is always the danger that an individual art therapist might be equally blind to her own unconscious socioeconomic, gender, or racial biases. These are so much a part of the dominant culture that even those who consider themselves open-minded may harbor prejudices of which they are completely unaware.

It would seem, therefore, that the ethics of respectful treatment require as much soul-searching about one's internalized attitudes regarding race and class, as about those regarding mental illness and other disabilities. The standards for training, practice, and ethics outlined in this chapter are central to responsible art therapy. They provide the necessary context within which the art therapist can use the tremendous power of the creative art experience to *help—without doing harm*.

Figure 11.12 Eleanor Roosevelt & Edith Kramer, Wiltwyck School.

Evolution of Political Action and Networks

Like a growing child, the field in its youth was much more concerned with internal familial issues than with the outside world, so it took some time before art therapists started to pay attention to political realities (**DVD 11.5**). Although art therapy was sometimes recognized by public figures—like Eleanor Roosevelt, pictured at an exhibit of art from Wiltwyck School **(Figure 11.12)** with art therapist Edith Kramer **(A)**—there was no organized effort at gaining recognition. Thanks to a gradual dawning of awareness, however, AATA slowly developed mechanisms for identifying and influencing relevant political activity.

Just as it might be hard to believe that there was ever any question about the wisdom of forming a national association, it might be equally surprising to learn that 30 years ago there was a similar ambivalence about being politically active. Thanks to the foresight of a few individuals, an early ad hoc group with a tiny budget grew into a *Governmental A&airs Committee* (GAC).[3] No one now questions the importance of being alert, nor of supporting lobbying activity at both state and federal levels. The Internet has greatly facilitated the work of this committee on pending legislation, since e-mails can be sent and responded to instantly, which has worked well on many an occasion.

In recent years, the GAC has been active in informing legislators at both the local and national level. For example, in 2004 an exhibit of artwork by older Americans was displayed in the Capitol rotunda **(B)**, and senators **(C)** and Congressmen were invited to attend **(D)**. A video was commissioned by the committee, *Beyond Words: Art Therapy with Older Adults* (Rubin, 2004b). A statement supporting art therapy was also entered into the *Congressional Record* by Senator Hillary Clinton **(Figure 11.13)** of New York **(E)**.

Much has been accomplished for art therapy by working with other creative arts therapy groups, both in legislative coalitions and through NCCATA—the National Coalition of Arts Therapy Associations—formed in 1979 (www.nccata.org). At the national level, there have been significant achievements, like being named in the regulations for legislation regarding

Figure 11.13 Senator Clinton viewing client art.

those with disabilities and for older adults (see Chapters 8 and 9). In 1979, the creative arts therapies obtained federal civil service job classifications. In 1980, they were noted in the Senate and House Report (96-712) on the Mental Health Systems Act. In 1993, art therapy was included in the Report of the Panel on Mind/Body Interventions for the National Institutes of Health (NIH) Office of Alternative Medicine.

In 2008 the presidents **(F)** of all of the associations that are part of NCCATA (art, drama, dance, music, poetry, and psychodrama) met in Washington, DC on Hill Day, presenting information to members of the House and the Senate regarding the creative arts therapies, both collectively **(G)** and individually **(H)**. In 2009, NCCATA participated in Arts Advocacy Day.

Communication with other art therapists in all geographic areas was greatly facilitated by the establishment within AATA of local affiliate chapters in 1982, an effort spearheaded by Don Cutcher of Ohio, where the Buckeye Art Therapy Association was formed years before the national one. The need for communication and representation finally overcame the complications of modifying local bylaws.

These groups can now become chapters by meeting relevant criteria. Each chapter sends delegates to an annual *Assembly of Affiliate Societies,* which then elects a *Speaker,* who sits on the AATA board of directors. These regional organizations throughout the country, over 30 of them, provide a network for sharing local political information, as well as the ability to respond rapidly when necessary.

Public and Professional Awareness

Art therapy has often been in the fortunate position of having friends in the right place at the right time **(DVD 11.6)**. These allies in key positions have made possible a number of significant events that have been critical in the rapid growth of the profession in the

United States. When psychiatrist Bertram Brown, for example, was Director of the National Institutes of Mental Health, his support facilitated many things, including the publication of two bibliographies of art therapy literature (Gantt & Schmal, 1974 **(A)**; Moore, 1981 **(B)**).

Starting in the 1960s, the Maurice Falk Medical Fund supported studies and films on dance **(C)**, drama **(D)**, and art therapy **(E)** in Pittsburgh. In June of 1979, Philip Hallen, president of the fund, suggested and funded a two-day *Conference on the Creative Arts Therapies*. This Washington meeting, hosted by the American Psychiatric Association (APA), was an opportunity to inform the invited decision makers. Perhaps even more important, the feedback from others led to the formation of NCCATA, mentioned above, which was also facilitated by support from the Falk Medical Fund. It was fortuitous for the arts therapies that Brown and Hallen were married to dance therapists, and that the then-president of APA was married to an art therapist.

Philip Hallen had also suggested that a *Task Panel on the Arts in Therapy & Environment* be part of the President's Commission on Mental Health. Thanks to his influence, since I was president of AATA at the time, I was able to serve as a consultant in 1978. In this role, I could speak in support of the lone creative arts therapist in the group. Together, we were eventually able to persuade the initially skeptical artist and educator members of the panel to include the arts therapies in their recommendations.[4]

From 1976 to 1982, I served on the board of the *National Committee * Arts for the Handicapped* (NCAH, now VSA Arts—www.vsaarts.org). At this critical period for public awareness of art therapy, it was very helpful to have a voice for the creative arts therapies in that group. In 1979, NCAH funded a meeting co-sponsored by the American Art Therapy Association and the National Art Education Association.[5]

As with the APA Conference and the Task Panel, these are examples of the kinds of public information activities essential to the growth and development of the new discipline of art therapy. Recognition and collaboration, by and with others with our interests, was the goal. Such alliances and representation are now widespread, for example the Society for the Arts in Healthcare (SAH), the Health Professionals Network (HPN), the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the American Association of State Counseling Boards (AASCB), and many others.

Concluding Thoughts

Despite the difficulties of learning to be an art therapist and of honing one's skills—not to mention the obstacles to recognition by others—the discipline continues to grow. It is impressive that a large percentage of students in art therapy training programs are pursuing a second career. They are often artists, teachers, nurses, or other health care professionals, who want to use their ability to help others to create in a more deeply satisfying fashion.

Because of the complexity of doing responsible art therapy, the required two years of full-time training—in theory, practice, and self-knowledge—are an essential first step. In order to become a Registered Art Therapist (ATR), the neophyte art therapist must accumulate at least 1000 hours of supervised work beyond the master's degree. To be board certified (ATR-BC), the registered art therapist must pass a written examination, and must accumulate 100 Continuing Education Credits every five years in order to maintain it.

Serious art therapists have always continued to learn, even before continuing education was mandated. And the motivation to do so is great, because being an art therapist is both terrifically challenging and intrinsically rewarding. I believe that art therapy is such immensely

satisfying work because it calls on so many human resources—feeling and intellect, heart and mind. Despite the challenges and complexities of doing a good job, unlocking someone's creativity is a profoundly gratifying experience. This is especially true if you love to watch people—as well as the unique images they create—being, in a very real sense, (re)born.

Endnotes

1. "Art Assessment with the Handicapped: Clinical, Aesthetic, and Ethical Considerations," by D. R. Henley, 1987, *Art Therapy, 4*(2), 57.
2. Multicultural Committee of AATA, Statement of Purpose, 2008–2009.
3. *AATA Governmental A&airs Sourcebook*, by American Art Therapy Association, 2007, Alexandria, VA: American Art Therapy Association.
4. *Role of the Arts in Therapy & Environment*, President's Commission on Mental Health, Task Panel Report, 1978, Washington, DC: National Committee, Arts for the Handicapped.
5. *Art in the Lives of Persons with Special Needs*, by National Art Education Association, 1981, Washington, DC: National Committee, Arts for the Handicapped.

CHAPTER 12
What Next?

What if imagination and art are not the frosting at all, but the fountainhead of human experience?

Rollo May

Perhaps even more today when the intellect and cerebral activity is too highly valued to the exclusion of feeling, man is turning for very life to the means of expression in the arts.

H. Irene Champernowne

Finding Out More About Art Therapy

Now that you have read something about art therapy, you might be wondering where to go from here. Whatever your level of interest, this book can offer no more than an overview of the discipline. Like an aerial map of the territory, it has hopefully given you a broad view of the lay of the land, historically and currently.

If you are not already enrolled in a training program, one excellent way to get a feeling for art therapy is to attend an annual conference of the American Art Therapy Association (AATA), where experiencing the workshops and hearing the presentations can give you a condensed introduction to the discipline. Another possibility is to take an introductory course in art therapy, if one is available where you live. Another excellent way to find out more is to *meet* with one or more art therapists, if that is at all possible. You can probably find someone through AATA, and possibly through the closest local association. Most art therapists are pleased to be of assistance.

You may also want to *volunteer* your services, which will give you a more intimate acquaintance with what it feels like to do this kind of work. Because of the wide diversity in populations and settings served by art therapists, you need to realize that any particular volunteer experience you may have, while it will be invaluable in your decision-making process, cannot possibly be broadly representative.

Another way to get an idea of what art therapy can look like in practice is to watch the film, *Art Therapy Has Many Faces* (www.expressivemedia.org/f1.html), which, like this

Figure 12.1 "Art Therapy Has Many Faces" original cover image.

book, is an overview of the field—from glimpses of the pioneers, to examples of different people **(Figure 12.1)**[1] doing and discussing art therapy with individuals, families, and groups **(DVD 12.1)**. It contains segments from art therapists with diverse orientations, working in a variety of settings and with different populations **(A)**. If any generalization can be made about art therapy, it is that it is like a multifaceted mosaic, made with many more materials than one could possibly count **(B)**.

Growing Art Therapy Literature

There is an extensive and rapidly growing literature that can either be skimmed or read in depth. I remember smiling inwardly and somewhat condescendingly when Bernard I. Levy in 1973 stressed the importance of requiring art therapy students to be familiar with what he termed "the literature in the field." At the time those words were first printed in *Guidelines for Art Therapy Training*, it seemed to me to be a rather bad joke, though being young and shy and new on the board, I never said so out loud.

Much to my skeptical surprise, however, it is now thirty years later and, in fact, the literature is growing, like the discipline itself, so rapidly that it is truly hard to keep up with it. A brief overview of its history and present state will orient the reader to what may be found on library shelves about art therapy. Although some of the early books are now out of print, libraries of universities with training programs usually have copies that may be borrowed through interlibrary loan. The same is true of the journals in the field, which are probably not available everywhere, but are likely to be on the shelves of schools that offer training.

Bibliographies There have been several useful bibliographies. The first was *Psychiatry and Psychology in the Visual Arts & Aesthetics* (Kiell, 1965), which included 278 listings under "Art Therapy," as well as related items in other categories. The second was a book titled

Remedial Art by a British art school (Pacey, 1972). The third was compiled for the National Institutes of Mental Health (NIMH), and was an annotated bibliography of 1175 items published between 1940 and 1973 on *Art Therapy* (Gantt & Schmal, 1974). Also funded by NIMH, *Art Therapy in Mental Health* was an annotated listing of 392 items covering the period between 1973 and 1981 (Moore, 1981). The following year there was an annotated bibliography on *Art Therapy & Group Work* (Hanes, 1982).

From its inception in 1961 until February of 1989, the *Bulletin of Art Therapy* (later the *American Journal of Art Therapy)* printed a regular listing (biannually until 1983, then annually) of "Recent Periodical Literature & Other Brief Publications." Computerized databases, including *Art Bibliographies*, *Current Contents/Social & Behavioral Sciences*, *ERIC, PsycINFO, Psychological Abstracts, PsycLIT, Research Alert, Scopus*, and the *Social Sciences Citation Index,* now include art therapy journals.

Journals Although the *Bulletin of Art Therapy* (later the *American Journal of Art Therapy*) was the first periodical in the field, founded in 1961, articles on art therapy and reports of related meetings were also published in *Confinia Psychiatrica*. This was the official organ of the International Society for the Psychopathology of Expression (SIPE). That journal was published from 1958 to 1980; the organization not only still exists, but has added the words *Art Therapy* to its name (www.online-art-therapy.com). In 1973 psychologist Ernest Harms founded *Art Psychotherapy,* which later changed its name and scope to *The Arts in Psychotherapy*. Like *Confinia Psychiatrica*, which was multilingual, it is also international, but all of the articles are written in English.

In 1983 the American Art Therapy Association, which was officially *affiliated* with the *American Journal of Art Therapy* from 1974 to 1983, began the publication of its own journal, *Art Therapy.* Most of these periodicals are quarterly, and all are still published regularly, except for *Confinia Psychiatrica*, which ended in 1980 and the *American Journal of Art Therapy,* which was published until 2001. Having served on the editorial boards of all of them, I can attest to a slow but steady increase in the quality of submitted manuscripts—in both form and content.

There are also art therapy journals in English in Great Britain (*Inscape)*, in Canada (*Canadian Art Therapy Association Journal*), in Australia/New Zealand (*ANZAT Journal)* and in other countries. The World Wide Web—the computer information pool accessible through the Internet—has a wealth of information about art therapy, which is increasing at least as fast as the literature in the field. This remarkable information superhighway will hopefully carry the vehicle of art therapy further and faster in this 21st century. For example, when looking up the Australian website, I found an excellent summary of literature[2] and references on evidence-based research in the field of art therapy.[3] The Internet is also becoming the place where films about art therapy, made by those in and out of the field, are being posted. A listing of some of these can be found on the website of Expressive Media (http://www.expressivemedia.org).

Books on Art Therapy Both art therapy journals in this country include regular book and videotape review sections. The growth has been astonishing. Just to give the reader some perspective, a bit of history is in order. In December of 1974, when I had to make a case for writing a book on art therapy as my dissertation, there were only 12 books by art therapists on art therapy (Betensky, 1973; Harris & Joseph, 1973; Hill, 1946, 1951; Kramer, 1958, 1971; Lyddiatt, 1971; Naumburg, 1947, 1950, 1953, 1966; Rhyne, 1973).

It wasn't hard to convince my committee of the need for more literature in this still-small discipline.

By the time I published *The Art of Art Therapy* ten years later (1984), there were just 19 more books by art therapists. But only 10 years after that, 100 additional books on art therapy had been published. Despite the fact that I had noticed my shelves gradually filling up and spilling over, I had not realized how extensively the literature in art therapy had grown in the intervening decade until I began reviewing it for this revised text.

Books by art therapists themselves have continued to proliferate, as well as more and more from our colleagues in Great Britain, where the first book in the field since Hill and Lyddiatt was published in 1984—*Art as Therapy* (Dalley, 1984). Because there are so many recent publications of note by art therapists on both sides of the Atlantic, an alphabetical list is available in the *References.* Selected books by individuals in related fields are also listed. Indeed, this revision took a great deal longer than I had anticipated, largely because there were 200 new books on art therapy and related areas.

Conference Proceedings Beginning with the seventh meeting in 1976, AATA has published annual *Proceedings,* the title of each being the theme of the particular conference. Until 1982, they contained many of the papers and panels in full, and these are listed in the Resources section at the back of this book, along with the titles for each year. Since 1987, one-page abstracts of conference presentations have been published annually, a list of which is available from the AATA office.

Although no longer published by S. Karger as *Psychiatry & Art*, editor Irene Jakab has continued to print the *Proceedings* of the American Society for Psychopathology of Expression (ASPE) and ISPE congresses when they have been held. Like AATA proceedings, the title of each one is the theme of the meeting. The Resources list also includes contact information for English-speaking professional associations. For information about specific countries, the best resource is the International Networking Group of Art Therapists.

Art Therapy as a Career

Reality Check: Jobs and Salaries

Perhaps you have already read, observed, volunteered, and gone to conferences, and you are becoming more and more convinced that art therapy is right for you. In fact, you may even be enrolled in a program of study. However, because art therapy is still so new and in some areas relatively unknown, you should be aware that jobs are not easy to find. And while the salaries are much better than they used to be, they are only recently becoming comparable to those in fields with similar training.

It is therefore critical that anyone deciding to study art therapy be absolutely certain that it is right for them. If it is, the rewards are immense, and the potential for personal growth and satisfaction is tremendous. But if income and job security are vital, you will want to be very sure as well as pragmatic about your career choice. Although some of my art therapy colleagues might consider this advice heretical, I think it is only fair and honest to describe the situation, at least as it is in 2009.

For a full-time job as an art therapist, following what is usually two years of full-time training, you may be able to find a job in your community if you are lucky, or you may need to relocate. If you cannot move, you may have to work hard to create or modify an employment situation where you can have the pleasure of using what you have learned. It is not easy

to find full-time employment, and many art therapists work at several part-time positions. Although art therapy is much better known than in the past, not all communities have a choice of positions. In areas that have had training programs for many years, however, and where students have interned in various settings, there is a much greater awareness of art therapy and its benefits, and therefore more jobs.

Credentialing in Other Areas

You might also want to consider the practical advantages of obtaining training—and perhaps certification or licensure—in a related field that is better established, and can therefore open more doors. If you plan to work with individuals who have disabilities, for example, you might want to become credentialed in special education or rehabilitation. Or, if you want to do psychotherapy in a clinical setting, you might consider a master's degree in social work or marriage & family counseling. And, if you desire further study, a doctorate in clinical psychology—either a PhD or the more clinically oriented PsyD—might be a practical choice.

Some training programs offer combined degrees, such as those in California, where marriage and family counseling is taught along with art therapy. And, as noted earlier, AATA's new education standards now require that programs include enough counseling courses for graduates to be eligible for that credential. Indeed, if art therapists continue to become eligible for licensure in more and more states through an avenue like counseling, it will not be necessary to obtain other credentials. The movement for "umbrella" licensing bills for master's level disciplines is growing, and art therapists are benefiting because of the much larger numbers of "counselors" who are promoting such legislation. It is equally important to be recognized by insurance companies, HMOs, PPOs, and managed care organizations, which currently hold many of the purse strings in health care in this country.

New Employment and Funding Sources

As noted in Chapter 10, employment for art therapists is rapidly becoming available in a wider range of settings, in some of which there is less need for the kind of credential required in the past. Prisons **(Figure 12.2)** and shelters, for example, do not necessarily require the same kind of license or certification as schools **(Figure 12.3)** or clinics **(Figure 12.4)**. Job openings in such places may even enhance earning power. It is also possible to obtain funding from other sources for programs in art therapy. Funding for the arts has become increasingly less available through the government, and may have to be sought and secured privately even more often in the future than in the past.

In the rapidly growing area of arts medicine, state arts councils and private foundations often support art programs in places like hospitals **(Figure 12.5)** and hospices. In the last decade artists in residence have increased in number; a phenomenon recognized by art therapists and which has caused considerable concern among many.

However, the current situation is quite different from the days before the existence of a professional association, when anyone offering art to a person in pain could call themselves an "art therapist." Now that there are mechanisms for certifying quality and competence in both the training and practice of art therapy, the challenge is to educate professionals and the public about the differences between the many possible providers of art to those who can benefit.

In my opinion, there will never be enough art therapists to serve all for whom the therapeutic potential of art would be helpful. Organizations like the International Expressive Arts Therapy Association (IEATA) and the Society for the Arts in Healthcare (SAH) have

Figure 12.2 Art therapy in a prison.

Figure 12.3 Art therapy in a school.

Figure 12.4 Art therapy in a clinic.

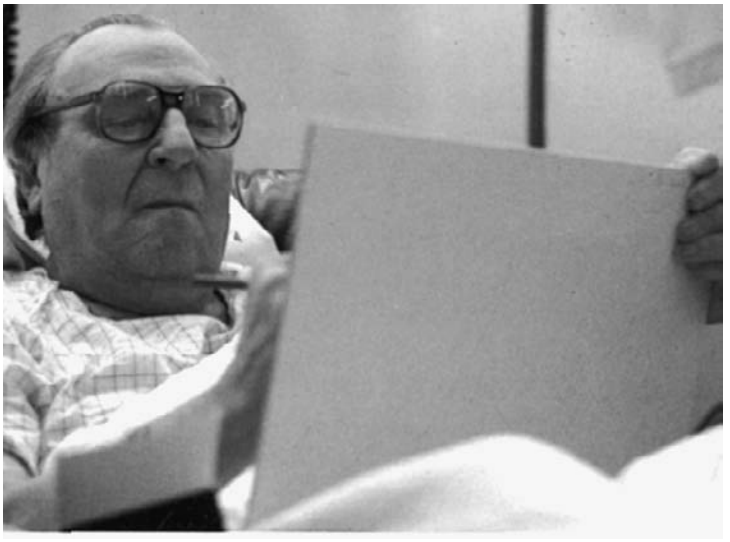

Figure 12.5 Art therapy in a hospital.

demonstrated that people with diverse preparation and training who offer the arts for healing can co-exist under the same umbrella.

I believe that this is a healthy development, because it means that more people in more places will have access to the healing power of art. The challenge for art therapists is to resist feeling threatened and becoming exclusive, and to instead find mutually supportive ways to work together, whether through collaboration, supervision, training, consultation, or some combination. (See Chapter 2 for a more extensive discussion of this topic.)

The Future of Art Therapy

Art Therapist Predictions: Past and Present

By now you may be wondering not so much where art therapy came from, or even where it is right now, but rather where it seems to be going. The present health care situation continues to be characterized by its volatility and unpredictability. Nevertheless, it is worth trying to identify probable and possible directions for this evolving discipline. During AATA's 25th anniversary year (1994), the editor of *Art Therapy* invited all those who had been honored by the association to answer the following questions: "How will the profession of art therapy change in the next 25 years? In other words, what is your vision of the 21st century art therapist?"

While reviewing the responses, I was reminded of a panel organized by Arthur Robbins at the 1979 conference entitled "The Future of Art Therapy: Fantasy vs. Reality." As a panel member, I had both wishful dreams and fearful nightmares about the field, and—like many—I found myself vacillating between great optimism and equally strong pessimism. By the time of AATA's 25th anniversary, despite the insecure and unpredictable quality of the times, I found myself much more squarely in the camp of those who saw the future as holding mostly promise for the therapeutic use of art, especially in nontraditional settings. It seemed to me that we had become remarkably well established for a profession that was still practically brand-new. We were even listed as one of the "top 40 niche specialties" in mental health in a 1995 newsletter for clinical practitioners. And in 2007 art therapy was listed in another survey as one of the "10 hot jobs" for that year.

Some of my colleagues were more pessimistic, warning that the degree of diversity we were encompassing within the definition of art therapy might be less enlivening than we would like to think and might even be hazardous to effective growth and communication. Many were concerned that art therapy would have a difficult time surviving the massive budget cutting of human services in the 1990s.

Worries about the instability of the system prompted a good deal of advice, including an injunction to conduct more rigorous outcome studies, some of which are now underway. Some recommended that art therapists form alliances with much larger groups with greater political power, such as the American Counseling Association with its 60,000 members, which has recently become a reality.

Some exhorted us to hold fast to our roots, and to the central vision of the healing power of art. Others urged us to let go of outmoded theories and ways of working, and to embrace and explore new concepts. Despite differences in the details, almost everyone remarked on the need to go beyond the past, to work with others in a more mature and collaborative fashion, and to embrace the incredible challenges of our times by offering creative solutions.

All suggested being active rather than passive. And, in one way or other, almost everyone had something to say about the risks and hazards of the previous trend toward "clinification"

in the field, at the possible expense of the unique thing we have to offer: *Art*. Some spoke of *soul* and some spoke of *systems*, and many spoke of the *sickness* of our times, of the crisis in our world, and of the desperate hunger for the kind of order and meaning and sense of effectiveness potentially available through the making of art.

In a subsequent issue of *Art Therapy* there was a follow-up piece by Jim Young of Santa Fe, New Mexico—with its rich indigenous tradition of a culture in which art is not only alive but central. He reflected on what leaders of both past and present generations had written, reminding us about where art therapy comes from. He offered the delightfully wishful vision that, "Art therapists of the future will play a major role in bringing art back to the communities as a healing force." Young called his article "The Re-enchantment of Art Therapy."[4] My only quarrel with him is that, for many of us, art therapy never lost its enchantment. Parenthetically, I now know that it certainly had for some of my colleagues (Kapitan, 2003).

The Future Panel of 1979 was in the student section of the conference, addressed to those who hold the future of any field in their hands. When I recently reread what I wrote 28 years ago, I was certain that we had come a long way, since my nightmares of 1979 no longer apply. In the area of art therapy *theory*, they consisted of "half digested hodgepodges, built on poorly-understood and inadequately-integrated ideas from various sources," much less common now than they were then. In the *practice* of art therapy, my reactions ranged "from deep admiration to horrified dismay." I am pleased to be able to say that there is considerably less sloppy thinking and careless work these days, though a little knowledge can still be a very dangerous thing in untrained hands.

In 1979 I had also written, "If we can somehow make the clinical skills of those who practice more synchronous with the power of their modality, I predict that we will not only be extremely successful, but also highly respected. There will then be no need to acquire credentials in other fields, nor any economic or political pressure to do so, for the sophistication and effectiveness of a qualified art therapist will be quite sufficient."

Even though the training of art therapists today is far superior to what was available 30 years ago, recognition in the marketplace has taken more time than I had imagined. Yet, while not quite there, we are nowhere near as far from achieving that goal as we were then. Excellent training and a flexible registration procedure were not sufficient to open enough doors. So it was necessary to create a national certification exam. So far, having a form of credentialing objective enough to be relevant for licensure or insurance coverage indeed seems to be leading to greater official recognition.

Art Therapy Has Much to Share

Art therapists have a great deal to contribute beyond direct work with identified patients. In addition to being helpful in many alternative settings, especially "normal" ones, art therapists have much to offer to colleagues in related fields. My psychoanalytic training, for example, has been immensely helpful in all of my work. I have wanted to share these understandings with art therapists, as I did in my chapter for *Approaches to Art Therapy* (2001). I had thought of writing a book for psychoanalysts about the power of art and imagery in analytically informed therapy. Instead, I ended up writing *Artful Therapy,* addressed to mental health clinicians of varying theoretical orientations (Rubin, 2005a).

Riley (Riley & Malchiodi, 2004) made a similar observation about the relevance of art therapy to systemic family therapy, noting how each enhances the other. Malchiodi (1998) wrote a book called *Understanding Children Through Their Drawings* for social workers, counselors, and other child therapists. Since then she has written other books to inform not

Figure 12.6 Describing drawing to a child psychiatrist.

just art therapists, but also clinicians in other fields and the general public (Malchiodi, 2002, 2007). The same is true for McNiff (1994, 1995, 1998b, 2003, 2004).

As noted in Chapter 2, art therapists do not own art, any more than we own therapy. It is my hope that we will be able to expand the reach of our modality by reaching out to both professionals and interested laypeople. The experience and skill of a trained art therapist in the use of materials with others is not literally transferable. But a little help can sometimes go a long way.

I was reminded of this recently, while consulting to a group of advanced residents in child psychiatry. These eager young physicians already had some minimal drawing supplies in their offices, and were curious about the pictures the children had done. Because they did not know how to "read" what had been communicated, they did not realize how very much their patients were actually telling them through their art **(Figure 12.6)**. And because they also did not know how to talk with the youngsters about their drawings, they had been unable to find out more about the messages being conveyed.

With just a little support, they were able to improve the quality of the art materials they made available to the children, greatly increasing their appeal and usage. And as these young child psychiatrists began to appreciate the richness of what was being expressed and worked through in the drawings, they began to see them as equivalent in value to the verbalizations they once viewed as the only "real" therapy. As they learned how to talk with the youngsters about their pictures, they were able to extend and expand their symbolic meaning, as well as their therapeutic effectiveness.

This was demonstrated so vividly in the art they brought in each week, that this group of residents was easily "sold" on the value of art in child therapy. I suspect they will be more likely to hire and to consult with art therapists in their future work. They are also more likely to value art as an outlet for their own children, and maybe even for themselves. They are some of the people I addressed in *Artful Therapy* (Rubin, 2005a).

Since art therapists are often involved in doing presentations and training for those in other fields, I am including two handouts that I have found helpful over the years **(DVD**

Figure 12.7 Computer art therapy.

12.3). They are very condensed, and work best if accompanied by direct experience with art materials, didactic presentation (images, film), and elaboration of their contents. One **(A)** is designed for teachers and contains some suggested ways to make art more therapeutic in their classrooms. The other **(B)** is designed for therapists, and lists some of the basic materials and approaches to the use of art in therapy.

Art Therapy in the Age of Virtual Reality

Twenty years ago I was invited to speak at an international conference on mental health and technology in Canada. Even though I was expected to tell the participants everything they ever wanted to know about art therapy in only 15 minutes, it was not that hard to articulate the importance of art therapy for an industrialized society.

The ensuing postmodern decades have seen the dominance of the computer chip and the emergence of new ways to know the world, primarily through the Internet. Kate Collie and her colleagues in British Columbia even created a way to treat people at great distances from mental health facilities through a computer art program **(Figure 12.7)** through cyberspace.[5] And there is now amazing software that can generate sophisticated animation or enable me to edit and compress video clips for the **DVD** that is in this book. Yet despite such developments, they cannot substitute for the physical hands-on aspect of art, as I wrote then:

> Although the technological revolution has wrought wondrous extensions of human perception, enabling us to see the otherwise invisible with instruments like the CAT scan or the electron microscope, it can never replace direct sensory experience as a mode of being alive, of coping, and of psychotherapy. Through art, human beings can *make visible the invisible*—which cannot be seen by any physical means. Through art, people can be literally *in touch* with their environments, in a fashion that is concrete and real, yet also imaginative and creative.
>
> For those whose inner worlds are confused and chaotic, who are unable to connect comfortably with life, art can be a vital avenue for finding and knowing themselves, others, and the world around them. For those who are out of control, art offers order. For

> those who are empty, art provides richness. For those who are lost, art gives meaning. For those whose resources are not fully available because of the psychological chains that bind their energies, art therapy can be the road to liberation, recovery, and renewal.[6]

As we honor art as the core of who we are and what we do, we also honor a deep respect for the creative potential and integrity of each and every individual we serve. We have great power in art therapy to help and to heal and to restore hope. If anything, the pressures of the 1990s and the environmental and human traumas of the 21st century have accentuated the unique values of art as an enlivening form of healing and of therapy, despite the field's continuing—and perhaps inevitable—confusion about its identity.

Artist or Therapist?

Some years ago, a freelance writer took a good long look at our field, read a great deal, and interviewed a lot of people. She then wrote an article entitled "Art Therapy's Growing Pains" (*Common Boundary,* 1994). The subtext indicated how far we have come, yet how we have struggled with the identity issue that has nagged us from the first. Her prescient words: "With certification looming, a burgeoning mental-health specialty finds itself at a crossroads. Should practitioners be artists or clinicians? The answer could change the role of creativity in the healing process."

Many of us believe that we are both artists *and* therapists, in which case there is little meaning to the question, and little anguish about the response **(DVD 12.2)**.[7] To ask if we are artists *or* therapists seems, therefore, to be a meaningless question, embodying a *false dichotomy.* That is also how many have viewed the heated disagreements between proponents of "art *as* therapy" and "art *psycho*therapy." Since helping the person(s) being served should be the prime concern, a responsible art therapist moves flexibly along the continuum of interventions, according to the needs of the moment. As in the skating and sailing metaphors noted in Chapter 7, it is impossible to move along without also being able to shift the emphasis between art and therapy—as needed.

Many years ago, I appeared as the Art Lady on a public television program created by an intelligent and compassionate man, Fred Rogers (*Mister Rogers' Neighborhood*). I often found myself quoting his lyrics to patients of all ages, such as "What do you do with the mad inside when you feel so mad you could bite?" Among the many possible ways he cited to express anger without doing harm was "You could pound some clay or some dough," one of the ways in which art therapy helps.

Another one of my favorites is "I like you as you are, exactly and precisely. I think you turned out nicely, and I like you as you are." Another is "You are special. You are the only one like you. I like you." Each, it seems to me, is about the kind of respect for the uniqueness and creativity of each human being that is the foundation of art therapy.

I'm not even sure that the name of the discipline is so important. I like *art therapy* myself because it contains a reference to each of our parents. Like all siblings, art therapists have varied configurations of appearance, talents, and personality. So of course we are different, but each in his or her own way is true to our common genetic background. The name of the field is not as vital as being true to our faith in the therapy of art, that is, the integrity of what we do and how we do it.

Need for Art in Times of Change

Fifty years ago, a Jungian analyst named Irene Champernowne spoke to a meeting of the British Association of Art Therapists. She said: "Perhaps even more today when the intellect

and cerebral activity is too highly valued to the exclusion of feeling, man is turning for very life to the means of expression in the arts."[8] The contemporary state of disequilibrium and of radical change in social structures is at least as great as it was then, and is both symptomatic and scary.

But, like a crisis in an individual or a family, it can also be an opportunity for change, for bold exploration, for freely and creatively addressing the question of how to make the healing power of art more accessible to more people. People in large numbers nowadays are turning to the arts as consumers. How much more therapeutic it would be if we could help them to become creators as well.

Art + Therapy = Art for Life

Several years ago I was asked to participate as a judge in an art show competition for those who had undergone transplant surgery. The project was called Art for Life, a most fitting way to think not only about this particular group of artists who were indeed fighting life-threatening illness, but also about art therapy. For it is, in a very profound and powerful way, *art for life*, for life lived as well, as freely, and as fully as possible. I hope that the benefits of art therapy will continue to be extended to ever-new people in ever-new places, and in ever-new ways.

Like the many movements of our time that reflect a search for meaning, art therapy may indeed help in the effort to save our world from the mess we have made of it. My own wishful image of the future of art therapy is that the swords of human aggression will be beaten not only into plowshares, but also into poems, paintings, and pottery. My mentor, Marvin Shapiro, used to point out that the oil from a gusher can be destructive; it can kill defenseless animals or ignite a fire. But that same energy, when channeled into a pipeline, can be a powerful and constructive force.

Frank Barron was a psychologist interested in the creative process who contributed a good deal through his writings, and who advised pioneer art therapist Janie Rhyne in her doctoral studies. He reminded us that the Latin root for *violence* and *vitality* is the same—*vis*. In other words, the energy can be expressed either way. And creating art has, for centuries, been a wonderful way to tame raging passions into forms of beauty.

Art is *sensual,* enabling you to feel your impact on the physical world, an increasingly rare experience in these technologically sophisticated but humanly impersonal times. And if you look at the world with *artist eyes*, you can see more loveliness in ordinary things. Shaun McNiff's (1995) *Earth Angels* is subtitled *Engaging the Sacred in Everyday Things*. Talk therapists work to *listen*, as well as to *hear*; art therapists seek to *see,* as well as to *look*. To see and to feel the beauty in the Self as well as in the World can be the gift of the kind of truly transformative therapy, which may be uniquely possible through art.

Endnotes

1. This image, which appears on the cover of that film, is a drawing created by Betty Jane, whose story is told in Chapter 1.
2. Edwards, C. (2008). Art therapy outcome studies reference list. Unpub. Ms.
3. Edwards, C., O'Brien, T. & King, R. (2008). *Research into process and outcome in art therapy*. Queensland, Australia: The University of Queensland.
4. Young, J. (1995). "The Re-enchantment of Art Therapy," by J. Young, 1995, *Art Therapy, 12*(3), 193.

5. "An Art Therapy Solution to a Telehealth Problem," by K. Collie & D. Cubranik, 1999, *Art Therapy, 16*(4).
6. "Responding to the Technological Revolution Through the Senses via Art Therapy," by J. A. Rubin, June 1986, Keynote Address, International Conference on Mental Health and Technology. University of British Columbia, Vancouver, Canada. June 1986.
7. The artists creating on this segment from an AATA QuickDraw session are all well-known art therapists.
8. Champernowne, I. (1968). *Inscape.*

Resources

Professional Associations

American Art Therapy Association (AATA)
11160-C1 South Lakes Drive, Suite 813
Reston, VA 20191
Phone: 888-290-0878
Fax: 571-333-5685
E-mail: info@arttherapy.org
Web site: www.arttherapy.org

American Society of Psychopathology of Expression (ASPE)
Irene Jakab, M.D., Ph.D.
74 Lawson Street
Brookline, MA 02146
Phone: 617-738-9821

Art Therapy Credentials Board (ATCB)
3 Terrace Way, Suite B
Greensboro, NC 27403
Phone: 877-213-2822
Fax: 336-482-2852
E-mail: atcb@nbcc.org
Web site: www.atcb.org

Association des art-therapeutes du Quebec (AATQ)
5764 Av. Monkland, #301
Montréal (Québec) H4A 1E9
CANADA
Phone: 514-990-5415
E mail: info@aatq.org
Web site: www.aatq.org

Australian & New Zealand Art Therapy Association (ANZATA)
E-mail: admin@anzata.org
Web site: www.anzata.org

British Association of Art Therapists (BAAT)
24-27 White Lion Street
London N1 9PD
Great Britain
Phone: 020-7686-4216
Fax: 020-7837-7945
E-mail: info@baat.org
Web site: www.baat.org

British Columbia Art Therapy Association
Suite 101
1001 West Broadway
Dept. 123, Vancouver, BC
Canada V6H 4E4
Phone: 604-878-6393
E-mail: info@bcarttherapy.com
Web site: www.bcarttherapy.com

Canadian Art Therapy Association (C.A.T.A.)
Web site: www.catainfo.ca

International Society for the Psychopathology of Expression & Art Therapy (S.I.P.E.)
E-mail: sipearther@aol.com
Web site: www.online-art-therapy.com

International Expressive Arts Therapy Association (IEATA)
P.O. Box 320399
San Francisco, CA 94132
Phone 415-522-8959
E-mail: info@ieta.org
Web site: www.ieata.org

International Networking Group of Art Therapists (ING/AT)
Geri Hurlbut
ING Key Networker
580 E. Main Street
Spartanburg, SC 29302
artherapie@juno.com
E-mail: ing_at@live.com
Web site: www.converse.edu/ingat

National Coalition of Creative Arts Therapy Associations (NCCATA)
8455 Colesville Road, Suite 1000
Silver Spring, MD
Phone: (301) 589-3300
Fax: (301) 589-5175

E-mail: info@nccata.org
Web site:www.nccata.org

Ontario Art Therapy Association (OATA)
611 Wonderland Road North, Suite 103
London, Ontario N6H 5N7
Canada
E-mail: communications@oata.ca
Web site: www.oata.ca/

Journals

American Journal of Art Therapy (formerly *Bulletin of Art Therapy*) 1961–2002
Art Therapy (American Art Therapy Association) www.arttherapyjournal.org, 1983–
Confinia Psychiatrica (International Society for Psychopathology of Expression, S. Karger) 1958–1980
Imagination, Cognition & Personality (Baywood Publishing Company) 1981–
International Journal of Art Therapy: Inscape (British Association of Art Therapists, Routledge)
International Journal of Arts Medicine (International Arts Medicine Association) 1992–1997
Journal of Mental Imagery (International Imagery Association, Brandon House) 1977–2006
The Arts in Psychotherapy (formerly *Art Psychotherapy*, Elsevier) 1973–

Conference Proceedings

American Art Therapy Association (AATA)
1976–1982: Full Papers (Various Editors)
1976: *Creativity & the Art Therapist's Identity* (Shoemaker & Gonick-Barris)
1977: *The Dynamics of Creativity* (Mandel, Shoemaker, & Hays)
1978: *Art Therapy: Expanding Horizons* (Gantt, Forrest, Silverman, & Shoemaker)
1979: *Focus on the Future: The Next Ten Years* (Gantt & Evans)
1980: *The Fine Art of Therapy* (Gantt & Whitman)
1981: *Art Therapy: A Bridge Between Worlds* (Di Maria, Kramer, & Rosner)
1982*: Art Therapy: Still Growing* (DiMaria, Kramer, & Roth)
1983– *Proceedings* (1 page abstracts; list available from AATA)

American Society of Psychopathology of Expression
Jakab, I. (Ed.). (1968). *Psychiatry & Art, Vol. I.* New York: S. Karger.
Jakab, I. (Ed.). (1970). *Art Interpretation and Art Therapy, Vol. II.* New York: S. Karger.
Jakab, I. (Ed.). (1971). *Conscious and Unconscious Expressive Art, Vol. III.* New York: S. Karger.
Jakab, I. (Ed.). (1975). *Transcultural Aspects of Psychiatric Art, Vol. IV.* New York: S. Karger.
Jakab, I. (Ed.) (1981). *The Personality of the Therapist*. Pittsburgh, PA: American Society of Psychopathology of Expression.

Jakab, I. (Ed.). (1986). *The Role of the Imagination in the Healing Process.* Pittsburgh, PA: American Society of Psychopathology of Expression.
Jakab, I. (Ed.). (1990). *Stress Management Through Art.* Boston, MA: American Society of Psychopathology of Expression.
Jakab, I. (1990). *Art Media as a Vehicle of Communication.* Brookline, MA: American Society of Psychopathology of Expression.
Jakab, I. & Miller, L. (Eds.) (1978). *Creativity & Psychotherapy* New York: S. Karger.

American Association for the Study of Mental Imagery

Klinger, E. (Ed.) (1980/1982). *Imagery: Concepts, Results & Applications* (Vol. 2). New York: Plenum.
Shorr, J. E., Sobel, G. E., Robin, P., & Cannella, J. (Eds.) (1979/1980). *Imagery: Its many dimensions & applications* (Vol 1). New York: Plenum.
Shorr, J. E., Sobel-Whittington, G. E., Robin, P., & Cannella, J. (Eds.) (1981/1983). *Imagery: Theoretical & Clinical Applications* (Vol. 3). New York: Plenum.

References

Abraham, R. (2004). *When words have lost their meaning.* Westport, CT: Praeger.
Achterberg, J. (2002). *Imagery in healing.* Boston: Shambhala.
Adamson, E. A. (1984). *Art as healing* London: Coventure.
Akeret, R. U. (1973). *Photoanalysis* New York: Peter H. Wyden, Inc.
Allan, J. (1988). *Inscapes of the child's world* Dallas, TX: Spring Publications.
Allan, J., & Bertoia, J. (1992). *Written paths to healing.* Dallas, TX: Spring Publications.
Allen, P. B. (1995). *Art is a way of knowing.* Boston: Shambhala.
Allen, P. B. (2005). *Art is a spiritual path.* Boston: Shambhala.
Alschuler, R., and Hattwick, L. W. (1947). *Painting and personality*, Vols. 1 and 2. Chicago: University of Chicago Press. (Revised one-volume ed., 1969)
American Art Therapy Association: Proceedings
1976–1982: Full Papers (Various Editors)
1976: *Creativity & the art therapist's identity* (Shoemaker & Gonick-Barris)
1977: *The dynamics of creativity* (Mandel, Shoemaker & Hays)
1978: *Art therapy: Expanding horizons* (Gantt, Forrest, Silverman, Shoemaker)
1979: *Focus on the future: The next ten years* (Gantt & Evans)
1980: *The fine art of therapy* (Gantt & Whitman)
1981: *Art therapy: A bridge between worlds* (Di Maria, Kramer & Rosner)
1982*: Art therapy: Still growing* (DiMaria, Kramer *&* Roth)
1983– (1 page abstracts) List available from AATA.
American Art Therapy Association (AATA). (1975). *Art therapy: Beginnings*. 16mm film.
American Art Therapy Association (AATA). (2005). *Using art in trauma recovery with children.* Alexandria, VA: American Art Therapy Association.
American Art Therapy Association (AATA). (2006). *Art therapy, posttraumatic stress disorder, and veterans.* Alexandria, VA: American Art Therapy Association.
American Art Therapy Association (AATA). (2007a). *AATA governmental a&airs sourcebook.* Alexandria, VA: American Art Therapy Association.
American Art Therapy Association (AATA). (2007b). *Art therapist among 10 hot jobs for 2007.* Alexandria, VA: American Art Therapy Association.
American Psychiatric Association (APA). (2000). *Diagnostic & statistical manual of mental disorders, 4th ed., Text Revision (DSM-IV-TR).* Washington, DC: American Psychiatric Association.
Anderson, C. (2000, 2003). *Videotape recordings of art therapy classes*. Emporia, KS: Emporia State University.

Anderson, F. E. (1991). *Courage! Together we heal! Mural messages from incest survivors.* VHS. Normal, IL: Illinois State University (feander17@hotmail.com).
Anderson, F. E. (1992). *Art for all the children.* (2nd ed.). Springfield, IL: Charles C. Thomas.
Anderson, F. E. (1994). *Art-centered education and therapy for children with disabilities.* Springfield, IL: Charles C. Thomas.
Anderson, W. (Ed.). (1977). *Therapy & the arts*. New York: Harper & Row.
Ansdell, G., & Pavlicevic, M. (2001). *Beginning research in the arts therapies*. London: Jessica Kingsley.
Arieti, S. (1976). *Creativity: The magic synthesis.* New York: Basic Books.
Arnheim, R. (1954). *Art and visual perception*. Berkeley: University of California Press.
Arnheim, R. (1967). *Toward a psychology of art*. Berkeley: University of California Press.
Arnheim, R. (1969). *Visual thinking*. Berkeley: University of California Press.
Arrington, D. B. (2001). *Home is where the art is: An art therapy approach to family therapy.* Springfield, IL: Charles C. Thomas.
Arrington, D. B. (Ed.). (2007). *Art, angst, & trauma: Right brain interventions with developmental issues.* Springfield, IL: Charles C. Thomas.
Ault, R. E. (1986). *Art therapy: The healing vision.* VHS. Topeka, KS: The Menninger Foundation.
Ault, R. E. (1996). *Drawing on the contours of the mind*. Unpublished manuscript.
Bach, S. R. (1990). *Life paints its own span: On the significance of spontaneous pictures by seriously ill children.* Zurich: Daimon.
Barnes, M., & Berke, J. (1971). *Mary Barnes: Two accounts of a journey through madness.* New York: Ballantine Books.
Barnes, M., & Scott, A. (1989). *Something sacred.* London: Free Association Books.
Baynes, H. G. (1961). *Mythology of the soul.* Princeton, NJ: Bollingen, 1961.
Beittel, K. E. (1973). *Alternatives for art education research*. Dubuque, IA: Wm. C. Brown.
Bejjani, F. J. (Ed.). (1993). *Current research in arts medicine.* Atlanta, GA: Cappella Books.
Bender, L. (Ed.). (1952). *Child psychiatric techniques*. Springfield, IL: Charles C. Thomas.
Berlyne, D. E. (1971). *Aesthetics and psychobiology.* New York: Meredith Corporation.
Bertman, S. L. (Ed.). (1999). *Grief and the healing arts: Creativity as therapy* (*Death, value, and meaning* series). Amityville, NY: Baywood Publishing Co.
Bertoia, J. (1993*). Drawings from a dying child: Insights into death from a Jungian perspective*. New York: Routledge.
Betensky, M. G. (1973). *Self-discovery through self-expression*. Springfield, IL: Charles C. Thomas.
Betensky, M. G. (1995). *What do you see?* London: Jessica Kingsley.
Betts, D. J. (Ed.). (2003). *Creative arts therapies approaches in adoption & foster care: Contemporary strategies for working with individuals & families.* Springfield, IL: Charles C. Thomas.
Bion, W. R. (1961). *Experiences in groups.* London: Routledge.
Birkhauser, P. (1991). *Light from the Darkness* (German & English).
Bonny, H. L., & Summer, L. (2002). *Music & consciousness: The evolution of guided imagery and music.* Gilsum, NH: Barcelona Publishers.
Bradway, K. & McCoard, B. (1997). *Sandplay.* New York: Routledge.
Bradway, K. Signell K., Spare, G., Stewart, C.T., Stewart, L.H., & Thompson, C. (1990*). Sandplay studies: Origins, theory and practice.* Boston: Sigo Press.
Brooke, S. L. (1997). *Art therapy with sexual abuse survivors.* Springfield, IL: Charles C. Thomas.
Brooke, S. L. (2004). *Tools of the trade: A therapist's guide to art therapy assessments* (2nd ed.). Springfield, IL: Charles C. Thomas.
Brooke, S. L. (2006). *Creative arts therapies manual: A guide to the history, theoretical approaches, assessment, and work with special populations of art, play, dance, music, drama, and poetry therapies.* Springfield, IL: Charles C. Thomas.
Brooke, S. L. (Ed.). (2007a). *The creative therapies and eating disorders*. Springfield, IL: Charles C. Thomas.
Brooke, S. L. (Ed.). (2007b). *The use of the creative therapies with sexual abuse survivors.* Springfield, IL: Charles C. Thomas.
Brown, W. (1967*). Introduction to psycho-iconography*. New York: Schering.

Buchalter, S. I. (2004). *A practical art therapy.* London: Jessica Kingsley.
Burns, R. C. (1987). *Kinetic house-tree-person drawings.* New York: Brunner/Mazel.
Burns, R. C. (1990). *A guide to family-centered circle drawings*. New York: Brunner/Mazel.
Burns, R. C., & Kaufman, S. H. (1970). *Kinetic family drawings.* New York: Brunner/Mazel.
Bush, J. (1997). *The handbook of school art therapy.* Springfield, IL: Charles C. Thomas.
Cameron, J. (2002). *The artist's way: A spiritual path to higher creativity.* (10th Anniversary Edition). New York: Jeremy P. Tarcher/Putnam.
Cameron, J. (2007). *The artist's way workbook.* New York: Jeremy P. Tarcher/Putnam.
Camilleri, V. A. (Ed.). (2007). *Healing the inner city child: Creative arts therapies with at-risk youth.* Philadelphia: Jessica Kingsley.
Campbell, J. (1993). *Creative art in groupwork.* Bicester, U.K.: Winslow.
Campbell, J., Liebmann, M., Brooks, F., Jones, J., & Ward, C. (Eds.). (1999). *Art therapy, race, & culture.* London: Jessica Kingsley.
Cane, F. (1951). *The artist in each of us.* London: Thames and Hudson. (1983 reprint distributed by Magnolia Street Publishers, Chicago, IL.)
Capacchione, L.(2001). *The creative journal: The art of finding yourself* . (2nd ed.). Franklin Lakes, NJ: New Page Books.
Capacchione, L. (2006). *The art of emotional healing.* Boston: Shambhala.
Caprio-Orsini, C. (1996*). A thousand words.* Quebec: Diverse City Press.
Cardinal, R. (1972*). Outsider art*. New York: Praeger.
Carey, L. J. (1999). *Sandplay therapy with children and families.* Northvale, NJ: Jason Aronson.
Carey, L. J. (2006). *Expressive & creative arts methods for trauma survivors.* London: Jessica Kingsley.
Case, C. (2005). *Imagining animals: Art, psychotherapy and primitive states of mind.* London: Routledge.
Case, C., & Dalley, T. (Eds.). (1990). *Working with children in art therapy*. London: Tavistock.
Case, C. & Dalley T. (2006). *The handbook of art therapy* (2nd ed.*).* London: Routledge.
Case, C., & Dalley, T. (Eds.). (2008). *Art therapy with children: From infancy to adolescence.* London: Routledge.
Cattanach, A. (Ed.), (1999). *Process in the arts therapies.* London: Jessica Kingsley.
Chickerneo, N. B. (1993). *Portraits of spirituality in recovery*. Springfield, IL: Charles C. Thomas.
Chodorow, J. (Ed.). (1997). *Jung on active imagination.* London: Routledge.
Clements, C. B., & Clements, R. D. (1984). *Art and mainstreaming.* Springfield, IL: Charles C. Thomas.
Cohen, B. M. (Ed.). (1985). *The diagnostic drawing series handbook*. (Available from Barry M. Cohen, P.O. Box 9853, Alexandria, Virginia, USA 22304).
Cohen, B. M. (Ed.). (1986/1994). *The diagnostic drawing series rating guide*. (Available from Barry M. Cohen, P.O. Box 9853, Alexandria, Virginia, USA 22304).
Cohen, B. M., Barnes, M.-M., & Rankin, A. B. (1995). *Managing traumatic stress through art.* Baltimore, MD: Sidran Press.
Cohen, B. M., & Cox, Carol T. (1995). *Telling without talking: Art as a window into the world of multiple personality.* New York: Norton.
Cohen, B. M., Giller, E., & W. L. (Eds.). (1991). *Multiple personality disorder from the inside out.* Baltimore, MD: Sidran Press.
Cohen, G. (2001). *The creative age: Awakening human potential in the second half of life.* New York: Harper.
Cohen, G. (2007). *The mature mind: The positive power of the aging brain* (2nd ed.). New York: Basic Books.
Colarusso, C. A. (1992). *Child & adult development: A psychoanalytic introduction for clinicians.* New York: Plenum Press.
Coleman, V. D., & Farris-Dufrene, P. B. (1996). *Art therapy & psychotherapy.* Bristol, PA: Taylor & Francis, 1996.
Coles, R. (1992). *Their eyes meeting the world: The drawings & paintings of children*, M. Sartor (Ed.). New York: Houghton Mifflin.
Collot d'Herbois, L. (1993*). Light, darkness, & colour in painting-therapy.* Hamburg: Goetheanum Press.
Connell, C. (1998). *Something understood: Art therapy in cancer care.* London: Wrexham Publications.
Consoli, J. J. (1991). *Psychimagery: Healing the child within.* Norfolk, VA: Psychimage Productions.
Cox, M. V. (1992). *Children's Drawings.* London: Penguin Books.

Cox, M. V. (1997). *Drawings of people by the under-5's.* London: Folmer Press.
Crowley, R., & Mills, J. (1989). *Cartoon magic.* New York: Brunner/Mazel.
Dalley, T. (Ed.). (1984). *Art as therapy: Introduction to art as a therapeutic technique.* London: Routledge.
Dalley, T., Halliday, D., Case, C., & Schaverien, J. (1987). *Images of art therapy.* London: Routledge.
Dalley, T., Rifkind, G., & Terry, K, (1993). *Three voices of art therapy: Image, client, therapist*. London: Routledge.
Danneker, K. (Ed.). (2004). *Internationale Perspektiven der Kunsttherapie* Graz, Austria: Nausner & Nausner.
Darley, S., & Heath, W. (2008). *The expressive arts activity book: A resource for professionals.* Springfield, IL: Charles C. Thomas.
Dax, Eric C. (1953). *Experimental studies in psychiatric art*. London: Faber & Faber.
Dewey, J. (1934). *Art as experience*. New York: Capricorn Books.
Di Leo, J. H. (1970). *Young children and their drawings*. New York: Brunner/Mazel.
Di Leo, J. H. (1974). *Children's drawings as diagnostic aids*. New York: Brunner/Mazel.
Di Leo, J. H. (1977). *Child development: Analysis and synthesis.* New York: Brunner/Mazel.
Di Leo, J. H. (1983). *Interpreting children's drawings.* New York: Brunner/Mazel.
Dissanayake, E. (1995). *Homo aestheticus: Where art comes from and why.* Seattle, WA: University of Washington Press.
Dokter, D. (Ed.). (1994). *Arts therapies & clients with eating disorders.* London: Jessica Kingsley.
Dokter, D. (Ed.). (1998). *Arts therapists, refugees and migrants: Reaching across borders*. London: Jessica Kingsley.
Drachnik, C. (1995). *Interpreting metaphors in children's drawings: A manual*. Burlingame, CA: Abbeygate Press.
Dreifuss-Kattan, E. (1990). *Cancer stories.* Hillsdale, NJ: The Analytic Press.
Dreikurs, S. E. (1986). *Cows can be purple: My life & art therapy.* Chicago, IL: Adler School of Professional Psychology.
Edwards, B. (1979). *Drawing on the right side of the brain.* Los Angeles, CA: Jeremy Tarcher.
Edwards, D. (2004). *Art therapy.* Thousand Oaks, CA: Sage Publications.
Erikson, E. H. (1950). *Childhood and society*. New York: W. W. Norton.
Erikson, E. H. (1977). *Toys and reasons.* New York: W.W. Norton.
Erikson, E. H., Erikson, J., & Kivnick, H. (1986). *Vital involvement in old age.* New York: W. W. Norton.
Erikson, J. M. (1976). *Activity, recovery & growth.* New York: W. W. Norton.
Evans, K., & Dubowski, J. (2001). *Art therapy with children on the autistic spectrum.* London: Jessica Kingsley.
Exner, J. E. (2002). *The Rorschach: Basic foundations and principles of Interpretation* (4th ed.). New York: Wiley.
Farrelly-Hansen, M. (Ed.). (2001). *Spirituality & art therapy: Living the connection.* London: Jessica Kingsley.
Farris-Dufrene, P. (1997). *Voices of color: Art & society in the Americas* (2nd ed.). New York: Prometheus Boos.
Fausek, D. (1997). *A practical guide to art therapy groups*. New York: Haworth.
Fay, C. G. (1994). *At the threshold: A journey to the sacred through the integration of Jungian psychology and the expressive arts.* Dallas, TX: C. G. Jung Center. Videotape.
Feder, B., & Feder, E. (1998). *The art & science of evaluation in the arts therapies: How do you know what's working?* Springfield, IL: Charles C. Thomas.
Feder, E., & Feder, B. (1981) *The expressive arts therapies.* Englewood Cliffs, NJ: Prentice-Hall.
Fein, S. (1976). *Heidi's horse.* Pleasant Hill, CA: Exelrod Press, 1976.
Felstiner, M. L. (1997). *To paint her life: Charlotte Salomon in the Nazi era.* Berkeley: University of California Press.
Fincher, S. F. (1991). *Creating mandalas.* Boston: Shambhala.
Fincher, S. F. (2000, 2004, 2006). *Coloring Mandalas 1, 2, 3.* Boston: Shambhala.
Fleshman, R., & Fryrear, J. L. (1981). *The arts in therapy.* Chicago: Nelson-Hall.
Fordham, M. (1944). *The life of childhood.* London: Kegan Paul.

Frank, L. K. (1948). *Projective methods.* Springfield, IL: Charles C. Thomas.
Freud, S. (1916–1917). *Introductory lectures on psycho-analysis.* Standard edition, Vol. 12, London: Hogarth Press.
Freud, S. (1923). *The ego and the id.* Standard edition, Vol. 19, London: Hogarth Press, 1964.
Freud, S. (1939). *An outline of psychoanalysis*. New York: W. W. Norton, 1949.
Frostig, K., & Essex, M. (1998). *Expressive arts therapies in the schools.* Springfield, IL: Charles C. Thomas.
Fryrear, J. L., & Corbit, I. E. (1992a). *Photo art therapy: A Jungian approach.* Springfield, IL: Charles C. Thomas.
Fryrear, J. L., & Corbit, I. E. (1992b). *Instant images: A guide to using photography in therapy.* Dubuque, IA: Kendall/ Hunt.
Fryrear, J. L., & Fleshman, R. (Eds.). (1981). *Videotherapy in mental health*. Springfield, IL: Charles C. Thomas.
Fugaro, Rocco A. L. (1985). *A manual of sequential art activities for classified children & adolescents.* Springfield, IL: Charles C. Thomas.
Fukurai, S. (1974). *How can I make what I cannot see?* New York: Van Nostrand Reinhold.
Furrer, P. J. (1982). *Art therapy activities & lesson plans for individuals & groups.* Springfield, IL: Charles C. Thomas.
Furth, G. M. (2002). *The secret world of drawings: A Jungian approach to healing through art* (2nd ed.). Toronto: Inner City Books.
Gaitskell, C. (1953). *Art education for slow learners*. Toronto: Ryerson Press.
Gantt, L., & Schmal, M. S. (1974). *Art therapy: A bibliography.* Washington, DC: National Institutes of Mental Health.
Gantt, L., & Tabone, C. (1998). *The formal elements art therapy scale: The rating manual.* Morgantown, WV: Gargoyle Press.
Gardner, H. (1980). *Artful scribbles: The significance of children's drawings*. New York: Basic Books.
Gardner, H. (1982*). Art, mind, and brain*. New York: Basic Books.
Gardner, R. (1971). *Therapeutic communication with children: The mutual storytelling technique.* New York: Science House.
Gardner, R. (1988). *The storytelling card game.* http://portal.creativetherapystore.com/portal/page?_pageid=94,54323&_dad=portal&_schema=PORTAL.
Gat, G. (2003). *Solution-oriented art therapy with children and adolescents.* VHS. Los Angeles, CA: Master's Work Video Productions.
Gedo, J. E. (1983). *Portraits of the artist.* New York: Guilford Press.
Gedo, M. M. (Ed.). (1985). *Psychoanalytic perspectives on art, Vol. 1.* Hillsdale, NJ: Analytic Press.
Gedo, M. M. (Ed.). (1987), *Psychoanalytic perspectives on art, Vol. 2.* Hillsdale, NJ: Analytic Press.
Gedo, M. M. (Ed.). (1988). *Psychoanalytic perspectives on art, Vol. 3.* Hillsdale, NJ: Analytic Press.
Gerber, N. (1996). *The Brief Art Therapy Screening Evaluation (BATSE).* Philadelphia: Author.
Gerity, L. (1999). *Creativity and the dissociative patient: Puppets, narrative and art in the treatment of survivors of childhood trauma.* London: Jessica Kingsley.
Gil, E. (1991). *The healing power of play: Working with abused children.* New York: Guilford Press.
Gil, E. (2006a). *Essentials of play therapy with abused children.* DVD & Guide. New York: Guilford Press.
Gil, E. (2006b). *Play therapy for severe psychological trauma.* DVD & Guide. New York: Guilford Press.
Gillespie, J. (1994). *The projective use of mother-and-child drawings*. New York: Brunner/Mazel.
Gilroy, A. (2006). *Art therapy, research and evidence based practice.* London: Routledge.
Gilroy, A., & Dalley, T. (Eds.). (1989). *Pictures at an exhibition*. London: Routledge.
Gilroy, A., & Lee, C. (Eds.). (1995). *Art & music: Therapy & research*. London: Routledge.
Gilroy, A., & McNeilly, G. (2000). *The changing shape of art therapy: New developments in theory & practice.* London: Jessica Kingsley.
Gladding, S.T. (2005). *Counseling as an art* (3rd ed.). Washington, DC: American Counseling Association.
Goldenberg, I., & Goldenberg, H. (2007). *Family therapy: An overview* (7th ed.) Los Angeles, CA: Brooks Cole
Golomb, C. (1974). *Young children's sculpture and drawing.* Cambridge, MA: Harvard University Press.
Golomb, C. (1992). *The child's creation of a pictorial world.* Berkeley, CA: University of California Press.

Golomb, C. (2002). *Child art in context: A cultural and comparative perspective.* Washington, DC: American Psychological Association.
Gong, S. (2004). *Yi Shu: The art of living with change: Integrating traditional Chinese medicine psychodrama & the creative arts*. St. Louis, MO: F. E. Robbins & Sons Press.
Goodenough, F. L. (1926). *Measurement of intelligence by drawings.* New York: Arno Press.
Goodnow, J. (1977). *Children drawing*. Cambridge, MA: Harvard University Press.
Graham-Pole, J. (2000). *Illness and the art of creative self-expression.* Oakland, CA: New Harbinger Publications.
Graves, S. K. (1994). *Expressions of healing.* Van Nuys, CA: Newcastle.
Green, G. (1969). *The artists of Terezin.* New York: Hawthorn Press.
Greenberg, P. (1987). *Visual arts & older people; Developing quality programs.* Springfield, IL: Charles C. Thomas.
Grözinger, W. (1955). *Scribbling, drawing, painting.* New York: Humanities Press.
Gussak, D., & Virshup, E. (Eds.). (1997). *Drawing time: Art therapy in prisons & forensic settings.* Chicago, IL: Magnolia Street Publishers.
Gypsycat Productions (1994). *Rudolf Arnheim: A life in art.* DVD. Berkeley, CA: Haas-Cohen, N.
Hagood, M. M. (2000). *The use of art in counseling child & adult survivors of sexual abuse.* London: Jessica Kingsley.
Hall, M. D., & Metcalf, E. W. (Eds.). (1994). *The artist outsider.* Washington, DC: Smithsonian Institution Press.
Hammer, E. F. (Ed.). (1958). *The clinical application of projective drawings.* Springfield, IL: Charles C. Thomas.
Hammer, E.F. (Ed.). (1997). *Advances in projective drawing interpretation.* Springfield, IL: Charles C. Thomas.
Hampe, R. (Ed.). (2007). *Crossing boundaries—Changes in consciousness and action in healthcare.* Berlin: Frank & Baum.
Hanes, K. M. (1982). *Art therapy and group work: An annotated bibliography*. Westport, CT: Greenwood Press.
Hanes, M. J. (1997). *Roads to the unconscious*. Bethany, OK: Wood 'n' Barnes Press.
Harding, Esther M. (1965). *The parental image: A study in analytical psychology.* New York: Putnam.
Harris, D. B. (1963). *Children's drawings as measures of intellectual maturity.* New York: Harcourt Brace & World.
Harris, J., & Joseph, C. (1973). *Murals of the mind: Image of a psychiatric community.* New York: International Universities Press.
Harris, P. (1993). *A child's story: Recovering through creativity.* St. Louis, MO: Cracom Corporation.
Hartley, R., Frank, L., & Goldenson, R. (1952). *Understanding children's play*. New York: Columbia University Press.
Hass-Cohen, N., & Carr, N. (Eds.). (2008). *Art therapy & clinical neuroscience.* London: Jessica Kingsley Press.
Hauschka, M. (1985). *Fundamentals of artistic therapy*. London: Rudolf Steiner Press.
Hedges, L. (1983). *Listening perspectives in psychotherapy.* New York: Jason Aronson.
Heegaard, M. E. (1996). *Facilitator guide for drawing out feelings* Minneapolis, MN: Woodland Press. (Also available: 18 workbooks for children and parents on different topics, 10 published by Fairfield Press in Minneapolis, MN since 2001).
Henley, D. (1992). *Exceptional children, exceptional art.* Worcester, MA: Davis Publications.
Henley, D. (2002). *Clayworks in art therapy: Plying the sacred circle.* London: Jessica Kingsley.
Herbert, G., Deschner, J.W, & Glazer, R. (2006). *Artists-in-residence: The creative center's approach to arts in healthcare.* New York: The Creative Center.
Herrera, H. (1983). *Frida: A biography of Frida Kahlo*. New York: Harper & Row.
Hieb, M. (2005). *Inner journeying through art-journaling: Learning to see and record your life as a work of art.* London: Jessica Kingsley.
Hill, A. (1945). *Art versus illness: A story of art therapy.* London: Allen & Unwin.
Hill, A. (1951). *Painting out illness.* London: Williams & Northgate.

Hillman, J. (1977). *Re-visioning psychology.* New York: Harper Paperbacks.
Hillman, J. (2004). *Archetypal psychology* (3rd ed.). Dallas, TX: Spring Publications.
Hinz, L. D. (2006). *Drawing from within: Using art to treat eating disorders.* London: Jessica Kingsley.
Hinz, L. D. (2009). *Expressive therapies continuum: A framework for using art in therapy.* New York: Routledge.
Hiscox, Anna, & Calisch, Abby. (Eds.). (1997). *Tapestry of cultural issues in art therapy.* London: Jessica Kingsley.
Hoffman, Donald, et.al. (1980). *Lifelong learning & the visual arts.* Reston, VA: National Art Education Association.
Hogan, Susan. (Ed.). (1997). *Feminist approaches to art therapy.* New York: Routledge.
Hogan, S. (2001). *Healing arts: The history of art therapy.* London: Jessica Kingsley.
Hogan, S. (Ed.). (2003). *Gender issues in art therapy.* London: Jessica Kingsley.
Homeyer, L. E., & Sweeney, D. (1998) *Sandtray: A practical manual.* Canyon Lake, TX: Linda Press.
Hornyak, L. M., & Baker, E. K. (Eds.). (1989). *Experiential therapies for eating disorders.* New York: Guilford Press, 1989.
Horovitz, E. G. (1999). *A leap of faith: The call to art.* Springfield, IL: Charles C. Thomas.
Horovitz. E. G. (2002a). *CATA/BATA.* Videotape. Rochester, NY: Julia Productions.
Horovitz, E. G. (2002b). *Spiritual art therapy: An alternate path* (2nd ed.). Springfield, IL: Charles C. Thomas.
Horovitz, E. G. (2005). *Art therapy as witness: A sacred guide.* Springfield, IL: Charles C. Thomas.
Horovitz, E.G. (Ed.). (2007). *Visually speaking: Art therapy & the deaf.* Springfield, IL: Charles C. Thomas.
Horowitz, M. J. (1983). *Image formation & psychotherapy* New York: Jason Aronson.
Hubble, M. A., Duncan, B. L., & Miler, S.D. (1999). *The heart & soul of change: What works in therapy.* Washington, DC: American Psychological Association.
Innes, A., & Hatfield, K. (2001). *Healing arts therapies and person-centred dementia care.* London: Jessica Kingsley.
Irwin, E. C., & Rubin, J. A. (2008). DVD. *The green creature within: Art & drama in group psychotherapy with adolescents* (2nd ed.). Pittsburgh, PA: Expressive Media, Inc.
Jakab, I. (Ed.). (1968). *Psychiatry & art, Vol. I.* New York: S. Karger.
Jakab, I. (Ed.). (1970). *Art interpretation and art therapy, vol. II.* New York: S. Karger.
Jakab, I. (Ed.). (1971). *Conscious and unconscious expressive art, vol. III.* New York: S. Karger.
Jakab, I. (Ed.). (1975). *Transcultural aspects of psychiatric art, vol. IV.* New York: S. Karger.
Jakab, I. (Ed.) (1981). *The personality of the therapist.* Pittsburgh, PA: American Society of Psychopathology of Expression.
Jakab, I. (1982). *Family video art therapy.* Pittsburgh, PA: Western Psychiatric Institute & Clinic Media Services.
Jakab, I. (Ed.). (1986). *The role of the imagination in the healing process.* Pittsburgh, PA: American Society of Psychopathology of Expression.
Jakab, I. (Ed.). (1990). *Stress management through art.* Boston, MA: American Society of Psychopathology of Expression.
Jakab, I. (1990). *Art media as a vehicle of communication.* Brookline, MA: American Society of Psychopathology of Expression.
Jakab, I. (1998). *Pictorial expression in psychiatry: Psychiatric and artistic analysis* (2nd ed.). Budapest: Akademiai Kiado.
Jakab, I. & Miller, L. (Eds.) (1978). *Creativity & psychotherapy* New York: S. Karger.
Jamison, K. R. (1993). *Touched with fire: Manic-depressive illness & the artistic temperament*. New York: Free Press.
Japan Broadcasting Corporation. (1977). *Unforgettable fire: Pictures drawn by atomic bomb survivors.* New York: Pantheon. (1981 American edition.)
Jeffrey, C. (1995). *That why child*. New York: Free Association Books.
Jennings, S., & Minde, A. (1993). *Art therapy & drama therapy.* London: Jessica Kingsley.
Jewish Museum of Prague. (1993). *I have not seen a butterfly around here.* Prague: The Jewish Museum.

Johnson, D. R. (1999). *Essays on the creative arts therapies: Imaging the birth of a profession*. Springfield, IL: Charles C. Thomas.
Jones, P. (2005). *The arts therapies: A revolution in healthcare*. London: Routledge.
Jung, C. G. (1964). *Man and his symbols*. New York: Doubleday, 1964.
Jung, C. G. (1972). *Mandala symbolism*. Princeton, NJ: Princeton University Press.
Junge, M.B. (2008). *Mourning, memory and life itself.* Springfield, IL: Charles C. Thomas.
Junge, M. B., & Asawa, Paige P. (1994). *A history of art therapy in the United States.* Mundelein, IL: American Art Therapy Association.
Junge, M. B., & Wadeson, H. (Eds.). (2007). *Architects of art therapy: Memoirs & life stories.* Springfield, IL: Charles C. Thomas.
Jungels, G. (1980). *Anna Shafer & her art.* 16-mm film. Buffalo, NY: Realist. On Rubin, J. A. (2008). *Art therapy with older adults* (Rev. ed.), www.expressivemedia.org.
Jungels, G. (1982). *To be remembered: Art & the older adult in therapeutic settings*. Buffalo, NY: Potentials Development.
Kahn, M., & Illusorio, S. (1990). *A look at medical art therapy.* Videotape. New York: Bellevue Hospital Activity Therapy Department.
Kalff, D. M. (1980). *Sandplay.* Boston: Sigo Press.
Kalmanowitz, D., & Lloyd, B. (Eds.). (2005). *Art therapy and political violence: With art, without illusion.* London: Routledge.
Kapitan, L. (2003). *Re-enchanting art therapy: Transformational practices for restoring creative vitality.* Springfield, IL: Charles C. Thomas.
Kaplan, F. (2000). *Art, science, and art therapy: Repainting the picture*. London: Jessica Kingsley.
Kaplan, F. (Ed.). (2007). *Art therapy and social action.* London: Jessica Kingsley.
Karkou, V., & Sanderson, P. (2006). *Arts therapies: A research based map of the field.* London: Elsevier.
Katz, F. L., & Katz, E. (1977). *Creative art of the developmentally disabled*. Oakland, CA: Creative Growth.
Katz, F. L., & Katz, E. (1990). *Art & disabilities* (Rev. ed.). Cambridge, MA: Brookline Books.
Kaufman, B., & Wohl, A. (1992). *Casualties of childhood: A developmental perspective on sexual abuse using projective drawings*. New York: Brunner/Mazel.
Kaye, C., & Blee, T. (Eds.). (1996). *The arts in health care*. London: Jessica Kingsley.
Kellogg, J. (1980). *MARI card test*. Clearwater, FL: Mandala Research Institute.
Kellogg, J. (2002). *Mandala: Path of beauty (*3rd ed.) Belleaire, FL: Association for Teachers of Mandala Assessment.
Kellogg, R. (1959). *What children scribble & why*. Palo Alto, CA: NP Pubs.
Kellogg, R. (1969). *Analyzing children's art*. Palo Alto, CA: National Press Books.
Kerr, C., Hoshino, J., Sutherland, J., Parashak, S. T., & McCarley, L. L. (2007). *Family art therapy: Foundations of theory & practice.* New York: Routledge.
Keyes, M. F. (1974/1992). *The inward journey: Art as therapy* (Rev. ed.) La Salle, IL: Open Court.
Kiell, N. (1965). *Psychiatry and psychology in the visual arts & aesthetics*. Madison, WI: University of Wisconsin Press.
Kinget, G. M. (1952). *The drawing completion test: A projective technique for the investigation of personality*. New York: Grune and Stratton.
Kirchner, L. (1977). *Dynamic drawing: Its therapeutic aspect*. Spring Valley, NY: Mercury Press.
Klein, M. (1932). *The psycho-analysis of children*. London: Hogarth.
Klepsch, M., & Logie, L. (1982*). Children draw and tell: An introduction to the projective use of children's human figure drawings.* New York: Brunner/Mazel.
Klinger, E. (Ed.). (1980/1982). *Imagery: Concepts, results & applications* (Vol. 2). New York: Plenum.
Klorer, P. G. (2000). *Expressive therapy with troubled children.* Northvale, NJ: Jason Aronson.
Kluft, E. (Ed.). (1993). *Expressive & functional therapies in the treatment of multiple personality disorder.* Springfield, IL: Charles C. Thomas.
Knill, P. J., Barba, H. N., & Fuchs, M. N. (2004). *Minstrels of soul: Intermodal expressive therapy* (2nd ed.). Toronto: E*G*S Press.
Knill, P. J., Levine, E. G., & Levine, S. K. (2005). *Principles & practice of expressive arts therapy: Toward a therapeutic aesthetics.* Toronto: E*G*S Press.

Koppitz, E. M. (1968). *Psychological evaluation of children's human figure drawings* New York: Grune & Stratton.
Koppitz, E. M. (1984). *Psychological evaluation of HFD's by middle-school pupils.* New York: Grune & Stratton.
Kovner, A. (Ed.). (1968). *Childhood under fire: Stories, poems and drawings by children during the six days war*. Israel: Sifriat Poalim.
Kramer, E. (1958). *Art therapy in a children's community.* Springfield, IL: Charles C. Thomas.
Kramer, E. (1971). *Art as therapy with children*. New York: Schocken Books.
Kramer, E. (1979). *Childhood and art therapy.* New York: Schocken Books.
Kramer, E. (2000). *Art as therapy: Collected papers*. Ed. by L. A. Gerity. London: Jessica Kingsley.
Krauss, D. A., & Fryrear, J. L. (1983). *Phototherapy in mental health*. Springfield, IL: Charles C. Thomas.
Kreitler, H., & Kreitler, S. (1972). *Psychology of the arts.* Durham, NC: Duke University Press.
Kris, E. (1952). *Psychoanalytic explorations in art.* New York: International Universities Press.
Kubie, L. (1958). *Neurotic Distortion of the Creative Process*. New York: Noonday Press.
Kwiatkowska, H. Y. (1978*). Family therapy and evaluation through art.* Springfield: Charles C. Thomas.
Labovitz Boik, B., & Goodwin, E.A. (2000) S*andplay therapy: A step-by-step manual for psychotherapists of diverse orientations.* New York: W. W. Norton.
Lacan, J. (2007). *Ecrits: The first complete edition in English* (B. Fink, Trans.) New York: W. W. Norton.
Lachman-Chapin, M. (1994). *Reverberations: Mothers & daughters.* Evanston, IL: Evanston Publishing Co., 1994.
Lahad, M. (2000). *Creative supervision: The use of expressive arts methods in supervision and Self-supervision.* London: Jessica Kingsley.
Laing, J., & Carrell, C. (Eds.). (1982). *The special unit, Barlinnie Prison: Its evolution through its art* Glasgow: Third Eye Center.
Lambert, D. (1995). *The life and art of Elizabeth "Grandma" Layton*. Waco, TX: WRS Publishing.
Landgarten, H. B. (1981). *Clinical art therapy*. New York: Brunner/Mazel.
Landgarten, H. B. (1987*). Family art psychotherapy: A clinical guide and casebook.* New York: Brunner/Mazel.
Landgarten, H. B. (1993). *Magazine photo collage.* New York: Brunner/Mazel.
Landgarten, H. B., & Lubbers, D. (Eds.). (1991). *Adult art psychotherapy*. New York: Brunner/Mazel.
Langer, S. K. (1953). *Feeling and form*. New York: Charles Scribner's Sons.
Lantz, B. (1955). *Easel Age Scale*. Los Angeles, California: Test Bureau.
Le Navenec, C-L., & Bridges, L. (Eds.). (2005). *Creating connections between nursing care & the creative arts therapies: Expanding the concept of holistic care.* Springfield, IL: Charles C. Thomas.
Leuner, H. (1984). *Guided a&ective imagery: Mental imagery in short-term psychotherapy. The basic course.* New York: Thieme Medical Publications.
Levens, M. (1995). *Eating disorders & magical control of the body: Treatment through art therapy*. New York: Routledge.
Levick, M. F. (1983). *They could not talk and so they drew: Children's styles of coping and thinking*. Springfield, IL: Charles C. Thomas.
Levick, M. F. (2001). *The Levick cognitive and emotional art therapy assessment* (LECATA) (2nd ed.). Boca Raton, FL: Author.
Levine, E. G. (2003). *Tending the fire: Studies in art, therapy & creativity* (2nd ed.). Toronto: E*G*S Press.
Levine, S. K. (1992). *Poesis*. Toronto: Palmerston Press, 1992.
Levine, S. K. (Ed.). (2002). *Crossing boundaries: Explorations in therapy & the arts.* Toronto: E*G*S Press.
Levine, S. K., & Levine, E G. (Eds.). (1999). *Foundations of expressive arts therapy.* London: Jessica Kingsley.
Levy, F. J. (Eds.). (1995). *Dance & other expressive art therapies: When words are not enough.* New York: Routledge.
Lewis, P. B. (1993). *Creative transformation: The healing power of the arts.* Wilmette, IL: Chiron Publications.
Ley, R. G. (1979). Cerebral asymmetries, emotional experience, and imagery: Implications for psychotherapy. In A. A. Sheikh & J. T. Shaffer (Eds.). *The potential of fantasy and imagination.* New York: Brandon House.

Liebmann, M. (Ed.). (1990). *Art therapy in practice.* London: Jessica Kingsley.
Liebmann, M. (Ed.). (1994). *Art therapy with oȧenders*. London: Jessica Kingsley.
Liebmann, M. (Ed.). (1996). *Arts approaches to conflict.* London: Jessica Kingsley.
Liebowitz, M. (1999). *Interpreting projective drawings: A self psychological approach.* New York: Brunner/Mazel.
Liebmann, M. (2004). *Art therapy for groups* (2nd ed.). London: Taylor & Francis.
Liebmann, M. (Ed.). (2008). *Art therapy and anger.* London: Jessica Kingsley.
Lindsay, Z. (1972). *Art and the handicapped child*. New York: Van Nostrand Reinhold.
Linesch, D. G. (1988). *Adolescent art therapy.* New York: Brunner/Mazel.
Linesch, D. G. (Ed.). (1993). *Art therapy with families in crisis: Overcoming resistance through nonverbal expression.* New York: Brunner/Mazel.
Linesch, D. G. (2000). *Celebrating family milestones: By making art together.* Toronto: Firefly Books.
Lisenco, Y. L. (1971). *Art not by eye*. New York: American Foundation for the Blind.
Lovell, S. (1990). *Symbolic healing: A personal story.* VHS. Santa Rosa, CA: Author.
Lowenfeld, M. (1971). *Play in childhood* (2nd ed.). New York: Wiley.
Lowenfeld, M. (1979). *The world technique.* London: George Allen and Unwin.
Lowenfeld, V. (1952). *The nature of creative activity* (2nd ed.). London: Routledge & Kegan Paul.
Lowenfeld, V. (1957). *Creative and mental growth* (3rd ed.) New York: Macmillan.
Lowenfeld, V., & Brittain, W. L. (1987). *Creative and mental growth* (8th ed.). Englewood Cliffs, NJ: Prentice-Hall.
Lucas, X. (1980). *Artists in group psychotherapy.* Athens: Litsas.
Luscher M. (1969). *The Lüscher color test*. New York: Random House.
Lusebrink, V. B. (1990). *Imagery and visual expression in therapy.* New York: Plenum Press.
Luthe, W. (1976). *Creativity mobilization technique*. New York: Grune & Stratton.
Lyddiatt, E. M. (1971). *Spontaneous painting & modeling.* London: Constable.
Lynn, D. (1994). *Myself resolved: An artist's experience with lymphoma.* New York: Author.
Lynn, D. (1996). *Healing through art.* New York: Author (www.darcyartist.com).
MacGregor, J. M. (1989). *The discovery of the art of the insane.* Princeton, NJ: Princeton University Press.
MacGregor, J. M. (1992). *Dwight Mackintosh: The boy who time forgot.* Oakland, CA: Creative Growth Art Center.
MacGregor, J. M. (1999). *Metamorphosis: The fiber art of Judith Scott.* Oakland, CA: Creative Growth Art Center.
Machover, K. (1949). *Personality projection in the drawing of the human figure*. Springfield, IL: Charles C. Thomas.
Maclagan, D. (2001). *Psychological aesthetics: Painting, feeling and making sense.* London: Jessica Kingsley.
Magniant, R. C. P. (Ed.). (2004). *Art therapy with older adults: A sourcebook.* Springfield, IL: Charles C. Thomas.
Makarova, E., & Seidman-Miller, R. (1999). *Friedl Deicker-Brandeis, Vienna 1891–Auschwitz 1944.* Los Angeles: Tallfellow Press.
Makin, S. A. (1994*). A consumer's guide to art therapy*. Springfield, IL: Charles C. Thomas.
Makin, S. R. (1999) *Therapeutic art directives and resources: Activities and initiatives for individuals and groups.* London: Jessica Kingsley.
Makin, S. R. (2000). *More than just a meal: The art of eating disorders.* London: Kingsley.
Malchiodi, C. A. (1997) *Breaking the silence: Art therapy with children from violent homes.* (2nd ed.). New York: Brunner-Routledge.
Malchiodi, C. A. (1998). *Understanding children's drawings.* New York: Guilford Press.
Malchiodi, C. A. (Ed.). (1999a). *Medical art therapy with children.* London: Jessica Kingsley.
Malchiodi, C. A. (Ed.). (1999b). *Medical art therapy with adults.* London: Jessica Kingsley.
Malchiodi, C. A. (2000). *Art therapy & computer technology: A virtual studio of possibilities.* London: Jessica Kingsley.
Malchiodi, C. A. (2002). *The soul's palette: Drawing on art's transformative powers.* Boston: Shambhala.
Malchiodi, C.A. (Ed.). (2003). *Handbook of art therapy.* NY: Guilford Press.
Malchiodi, C.A. (2004) (Ed.). *Expressive arts therapies.* New York: Guilford Press.

Malchiodi, C. A. (2007). *The art therapy sourcebook* (2nd ed.). Lincolnwood, IL: Lowell House.
Malchiodi, C. A. (2008). (Ed.). *Creative interventions with traumatized children.* New York: The Guilford Press.
Malchiodi, C. A., & Riley, S. (1996). *Supervision & related issues*. Chicago: Magnolia Street Publishers.
Marvasti, J. A. (Ed.). (2004). *Psychiatric treatment of victims and survivors of sexual trauma.* Springfield, IL: Charles C. Thomas.
May, R. (1975). *The courage to create*. New York: W. W. Norton.
McElhaney, M. (1969). *Clinical psychological assessment of the human figure drawing.* Springfield, IL: Charles C. Thomas.
McGoldrick, M., & Gerson, R. (1985). *Genograms in family assessment*. New York: W. W. Norton.
McNally, S. P. (2001). *Sandplay: A sourcebook for play therapists.* Campbell, CA: Universe.
McNeilly, G. (2006). *Group analytic art therapy.* London: Jessica Kingsley.
McNiff, S. (1981). *The arts and psychotherapy*. Springfield, IL: Charles C. Thomas.
McNiff, S. (1986). *Educating the creative arts therapist*. Springfield, IL: Charles C. Thomas.
McNiff, S. (1988). *Fundamentals of art therapy.* Springfield, IL: Charles C. Thomas.
McNiff, S. (1989). *Depth psychology of art*. Springfield, IL: Charles C. Thomas.
McNiff, S. (1994). *Art as medicine.* Boston: Shambhala, 1994.
McNiff, S. (1995). *Earth angels: Engaging the sacred in everyday things*. Boston: Shambhala.
McNiff, S. (1998a). *Art-based research.* London: Jessica Kingsley.
McNiff, S. (1998b). *Trust the process: An artistic guide to letting go.* Boston: Shambhala.
McNiff, S. (2003). *Creating with others: The practice of imagination in life, art, and the workplace.* Boston: Shambhala.
McNiff, S. (2004). *Art heals: How creativity cures the soul.* Boston: Shambhala.
Meares, A. (1957). *Hypnography.* Springfield, IL: Charles C. Thomas.
Meares, A. (1958). *The door of serenity.* London: Faber & Faber.
Meares, A. (1960). *Shapes of sanity.* Springfield, IL: Charles C. Thomas.
Meerloo, J. A. M. (1968). *Creativity and eternization*. New York: Humanities Press.
Meijer-Degen, F. (2006). *Coping with loss and trauma through art therapy.* Delft: Eburon Academic Publishers.
Michael, J. A. (Ed.). (1982). *The Lowenfeld lectures*. University Park, PA: Pennsylvania State University Press.
Milia, D. (2000). *Self-mutilation and art therapy: Violent creation.* London: Jessica Kingsley.
Miller, A. (1986). *Pictures of a childhood.* New York: Farrar, Straus & Giroux.
Milner, M. (1957). *On not being able to paint*. New York: International Universities Press.
Milner, M. (1969). *The hands of the living god.* New York: International Universities Press.
Milner, M. (1987). *The suppressed madness of sane men*. London: Tavistock, 1987.
Mitchell, R. R., & Friedman, H. S. (1994). *Sandplay: Past, present and future.* New York: Routledge.
Mitchell, S. A., & Aron, L. (Eds.). (1999). *Relational psychoanalysis: The emergence of a tradition.* New York: The Analytic Press.
Moon, B. L. (1992). *Essentials of art therapy training & practice.* Springfield, IL: Charles C. Thomas.
Moon, B. L. (1994). *Introduction to art therapy.* Springfield, IL: Charles C. Thomas.
Moon, B. L. (1995). *Existential art therapy* (2nd ed.). Springfield, IL: Charles C. Thomas.
Moon, B. L. (1996). *Art & soul: Reflections on an artistic psychology.* Springfield, IL: Charles C. Thomas.
Moon, B. L. (1998). *The dynamics of art as therapy with adolescents.* Springfield, IL: Charles C. Thomas.
Moon, B. L. (2006). *Ethical issues in art therapy* (2nd ed.). Springfield, IL: Charles C. Thomas.
Moon, B. L. (2007). *The role of metaphor in art therapy: Theory, method & experience.* Springfield, IL: Charles C. Thomas.
Moon, C. H. (2002). *Studio art therapy: Cultivating the artist identity in the art therapist.* London: Jessica Kingsley.
Moore, R. W. (1981). *Art therapy in mental health*. Washington: National Institutes of Mental Health.
Morgenthaler, W. (1921). *Madness and art.* Lincoln, NB: University of Nebraska Press.
Moriya, D. (2000). *Art therapy in schools.* Boca Raton, FL: Author.
Morris, D. *The biology of art*. New York: Alfred A. Knopf, 1962.

Mortensen, K. V. (1991). *Form and content in children's human figure drawings*. New York: New York University Press.
Moustakas, C. E. (1953). *Children in play therapy*. New York: Ballantine Books.
Moustakas, C. E. (1959). *Psychotherapy with children*. New York: Ballantine Books.
Mueller White, L. (2002). *Printmaking as therapy: Frameworks for freedom.* Philadelphia: Jessica Kingsley.
Murphy, J. (Ed.). (2001). *Art therapy with young survivors of sexual abuse.* Philadelphia, PA: Taylor & Francis.
Naevestad, M. (1979). *The colors of rage and love.* London: Whitefriars Press.
Naumburg, M. (1928). *The child and the world*. New York. Harcourt, Brace, & World.
Naumburg, M. (1947/1973). Studies of the "free" art expression of behavior problem children and adolescents as a means of diagnosis and therapy. *Nervous and Mental Disease Monograph 17* (2nd ed., *An introduction to art therapy*. New York: Teachers College Press, 1973).
Naumburg, M. (1950). *Schizophrenic art: Its meaning in psychotherapy*. New York: Grune & Stratton.
Naumburg, M. (1953). *Psychoneurotic art: Its function in psychotherapy*. New York: Grune & Stratton.
Naumburg, M. (1966). *Dynamically oriented art therapy: Its principles and practices.* New York: Grune & Stratton.
Neumann, E. (1971). *Art and the creative unconscious*. Princeton, NJ: Princeton University Press.
Nichols, J., & Garrett, A. (1995). *Drawing and coloring for your life.* Overland Park, KS: Gingerbread Castle Publications.
Nicolaides, K. (1941). *The natural way to draw.* New York: Houghton Mifflin.
Nucho, A. O. (1995). *Spontaneous creative imagery: Problem-solving and life-enhancing skills.* Springfield, IL: Charles C. Thomas.
Nucho, A. O. (2003). *Psychocybernetic model of art therapy* (2nd ed.) Springfield, IL: Thomas.
Oaklander, V. (1988). *Windows to our children: A Gestalt therapy approach to children and adolescents* (2nd ed.). Highland, NY: The Gestalt Journal Press.
Oster, G. D., & Crone, P. G. (2004). *Using drawings in assessment and therapy* (2nd ed.). New York: Brunner-Routledge.
Oster, G. D., & Montgomery, S. (1996). *Clinical uses of drawings.* Northvale, NJ: Jason Aronson.
Pacey, P. (1972). *Remedial art: A bibliography.* St. Albans School of Art.
Palmer, J., & Nash, F. (1991). *The hospital arts handbook*. Durham, NC: Duke University Medical Center.
Panter, B., Panter, M. L., Virshup, E., & Virshup, B. (Eds.). (1995). *Creativity and madness: Psychological studies of art and artists*. Burbank, CA: AIMED Press, 1995.
Paraskevas, C. B. (1979). *A structural approach to art therapy methods.* Elmsford, NY: Collegium Publishers.
Pasto, T. (1964). *The space-frame experience in art*. New York: Barnes.
Payne, Helen (Ed.). (1994). *Handbook of inquiry in the arts therapies: One river, many currents*. London: Jessica Kingsley.
Petrie, M. (1946). *Art and regeneration*. London: Paul Elek, 1946.
Pickford, R. W. (1967). *Studies in psychiatric art*. Springfield, IL: Charles C. Thomas.
Plokker, J. H. (1965). *Art from the mentally disturbed.* Boston: Little, Brown, 1965.
Polster, E. (1990). *Every person's life is worth a novel* (2nd ed.). New York: W.W. Norton.
Pratt, M., & Wood, M. (Eds.). (1998). *Art as therapy in palliative care: The creative response.* London: Routledge.
President's Commission on Mental Health, Task Panel Report (1978). *Role of the arts in therapy & environment*. Washington, DC: National Committee, Arts for the Handicapped.
Prinzhorn, H. (1922). *Artistry of the mentally ill*. New York: Springer.
Proulx, L. (2002). *Strengthening emotional ties through parent-child-dyad art therapy.* London: Jessica Kingsley.
Rambert, M. (1949). *Children in conflict*. New York: International Universities Press.
Rappaport, L. (2009). *Focusing-oriented art therapy.* London: Jessica Kingsley.
Read, H. (1958). *Education through art*. New York: Pantheon Books.
Rees, M. (Ed.). (1998). *Drawing on di&erence: Art therapy with people who have learning difficulties.* New York: Routledge.

Reichard, G. A. (1977). *Navajo medicine man sand paintings.* New York: Dover.
Rhyne, J. (1995). *The gestalt art experience: Patterns that connect* (2nd ed.) Chicago, IL: Magnolia Street Publishers.
Richards, M. C. (1962). *Centering: In pottery, poetry, and the person.* Middletown, CT: Wesleyan University Press.
Richards, M. C. (1966). *The crossing point*. Middletown, CT: Wesleyan University Press.
Ridker, C., & Savage, P. (1996). *Railing against the rush of years*. Pittsburgh, PA: Unfinished Monument Press.
Riley, S. (1999). *Contemporary art therapy with adolescents.* London: Jessica Kingsley.
Riley, S. (2001). *Group process made visible: The use of art in group therapy.* New York: Brunner-Routledge.
Riley, S., & Malchiodi, C. A. (2004). *Integrative approaches to family art therapy* (2nd ed.). Chicago, IL: Magnolia Street Publishers.
Robbins, A. (1980). *Expressive therapy.* New York: Human Sciences Press, 1980.
Robbins, A. (1987). *The artist as therapist*. New York: Human Sciences Press.
Robbins, A. (1988). *Between therapists.* New York: Human Sciences, 1988.
Robbins, A. (1989). *The psychoaesthetic experience*. New York: Human Sciences Press, 1989.
Robbins, A. (1994*). A multi-modal approach to creative art therapy.* Bristol, PA: Jessica Kingsley, 1994.
Robbins, A. (Ed.). (1997). *Therapeutic presence*. London: Jessica Kingsley.
Robbins, A. *Dancing on my father's blood.* Videotape. London: Jessica Kingsley.
Robbins, A., & Sibley, L. (1976). *Creative art therapy.* New York: Brunner/Mazel.
Robertson, S. (1963). *Rosegarden and labyrinth*. London: Routledge & Kegan Paul.
Rogers, E. (Ed.). (2007). *The art of grief: The use of expressive arts in a grief support group (death, dying and bereavement).* New York: Routledge.
Rogers, N. (1993). *The creative connection: Expressive arts as healing.* Palo Alto, CA: Science & Behavior Books.
Rollins, J. (2004). *Arts activities for children at bedside.* Washington, DC: VSA Arts Connection.
Rollins, J., & Mahan, C. (1996). *From artist to artist-in-residence: Preparing artists to work in pediatric healthcare settings.* Washington, DC: Rollins & Associates. Nicolas-Hays.
Rosal, M. (1996). *Approaches to art therapy with children.* Burlingame, CA: Abbeygate Press.
Rosen, D. (2002). *Transforming depression: Healing the soul through creativity* (2nd ed.). New York:
Rosenthal, R., & Jacobson, L. (1968). *Pygmalion in the classroom*. New York: Holt & Rinehart.
Ross, C. (1997). *Something to draw on: Activities and interventions using an art therapy approach.* London: Jessica Kingsley.
Rubin, J. A. (1984). *The art of art therapy.* New York: Brunner/Mazel.
Rubin, J. A. (1998). *Art therapy: An introduction.* New York: Brunner/Mazel.
Rubin, J. A. (Ed.). (2001). *Approaches to art therapy: Theory & technique* (2nd ed.). New York: Brunner-Routledge.
Rubin, J. A. (2002). *My mom and dad don't live together anymore.* Washington, DC: 'Magination Press (American Psychological Association).
Rubin, J. A. (2005a). *Artful therapy.* New York: John Wiley & Sons.
Rubin, J. A. (2005b). *Child art therapy: Third anniversary edition.* New York: John Wiley & Sons.
Rubin, J. A. (2008a). (Rev.) *Art therapy has many faces*. DVD. Pittsburgh, PA: Expressive Media, Inc.
Rubin, J. A. (2008b). *Art therapy with older adults.* DVD. Pittsburgh, PA: Expressive Media, Inc.
Rubin, J. A. (2008c). *The arts as therapy with children.* DVD. Pittsburgh, PA: Expressive Media, Inc.
Rubin, J. A. (2008d). *Art therapy with blind children.* DVD. Pittsburgh, PA: Expressive Media, Inc.
Rubin, J. A. (2009a). *Hospital drawing book.* Pittsburgh, PA: Expressive Media, Inc.
Rubin, J. A. (2009b). *Me, Myself, & I.* Pittsburgh, PA: Expressive Media, Inc.
Rubin, J. A. (2009c). *When bad things happen.* Pittsburgh, PA: Expressive Media, Inc.
Rugh, M. M., & Ringold, F. (1989). *Making your own mark: A drawing & writing guide for senior citizens.* Tulsa, OK: Council Oak Books, 1989.
Rutten-Sarris, M. (2005). *Emerging body language series.* DVD. Nijmegen, NL: Arts Therapy Centre
Ryce-Menuhin, J. (1992). *Jungian sandplay*. London: Routledge.
Safran, D. (2002). *Art therapy & ADH/HD: Diagnostic & therapeutic approaches.* London: Jessica Kingsley.

Salomon, C. (1998). *Life? Or theater? The work of Charlotte Salomon*. London: Royal Academy of Arts.
Sandle, D. (Ed.). (1998). *Development and diversity: New applications in art therapy.* New York: Free Association Books.
Sarason, S. B. (1990). *The challenge of art to psychology.* New Haven, CT: Yale University Press.
Schaeffer-Simmern, H. (1961). *The unfolding of artistic activity*. Berkeley: University of California Press.
Schaverien, J. (1992). *The revealing image: Analytical art psychotherapy in theory & practice.* London: Routledge.
Schaverien, J. (1995). *Desire & the female therapist: Engendered gazes in psychotherapy & art therapy.* London: Routledge.
Schaverien, J., & Case, C. (Eds.). (2007). *Supervision of art psychotherapy: A theoretical & practical handbook*. London: Routledge.
Schaverien, J., & Killick, Katherine (Eds.). (1997). *Art, psychotherapy & psychosis*. New York: Routledge.
Schechtman, A. (1976). *Insights: Art in special education.* Millburn, NJ: Art Educators of New Jersey.
Schilder, P. (1950). *The image and appearance of the human body.* New York: Wiley.
Schildkrout, M. S., Shenker, I. R., & Sonnenblick, M. (1972). *Human figure drawings in adolescence*. New York: Brunner/Mazel.
Schiller, F. (1875). *Essays, aesthetical and philosophical*. London: George Bell.
Schneetz, M. (2005). *The healing flow: Artistic expression in therapy.* London: Jessica Kingsley.
Searle, Y., & Streng, I. (Eds.). (2001). *Where analysis meets the arts: The integration of the arts therapies with psychoanalytic theory.* London: Karnac Books.
Schreiber, F. R. (1974). *Sybil.* New York: Warner Books.
Schroder, D. (2005). *Little windows into art therapy: Small openings for beginning therapists.* London: Jessica Kingsley.
Sechehaye, M. (1951). *Symbolic realization.* New York: International Universities Press.
Seftel, L. (2006). *Grief unseen: Healing pregnancy loss through the arts*. London: Jessica Kingsley.
Seiden, D. (2007). *Artobiography*. Chicago: Fisheye Graphic Services, Inc.
Selfe, L. (1977). *Nadia: A case study of extraordinary drawing ability in an autistic child*. New York: Academic Press.
Seki, N. (Ed.) (2008). *Atarashii geijyutsu no nagare-creative arts*. Tokyo, Japan: Film Art Inc.
Shaw, R. F. (1938). *Finger painting.* Boston: Little, Brown and Company.
Shorr, J. E., Sobel, G. E., Robin, P., & Cannella, J. (Eds.). (1980). *Imagery: Its many dimensions & applications* (Vol. 1). New York: Plenum.
Shorr, J. E., Sobel-Whittington, G. E., Robin, P., & Cannella, J. (Eds.). (1983). *Imagery: Theoretical & clinical applications* (Vol. 3). New York: Plenum.
Siegel, B. (1986). *Love, medicine, and miracles.* New York: Harper & Row.
Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience.* New York: The Guilford Press.
Silver, R. A. (1978). *Developing cognitive and creative skills in art: Programs for children with communication disorders or learning disabilities*. Baltimore, MD: University Park Press.
Silver, R. A. (2001) *Art as language: Access to thoughts and feelings through stimulus drawings.* New York: Brunner-Routledge.
Silver, R. A. (2002*). Three art assessments: Silver drawing test of cognition & emotion; Draw a story: Screening for depression; & Stimulus drawings and techniques.* New York: Brunner-Routledge.
Silver, R. A. (2005). (Ed.). *Aggression and depression assessed through art: Using draw-a-story to identify children and adolescents at risk.* New York: Routledge.
Silver, R. A. (2007). *The silver drawing test and draw a story: Assessing depression, aggression, & cognitive skills.* New York: Routledge.
Silverstone, L. (1997). *Art therapy—The person-centred way* (2nd ed.) London: Jessica Kingsley.
Silverstone, L. (2008). *Art therapy exercises: Inspirational & practical ideas to stimulate the imagination*. London: Jessica Kingsley.
Simon, R. (1992*). The symbolism of style*. New York: Routledge.
Simon, R. (1997). *Symbolic images in art as therapy.* New York: Routledge, 1997.

Simon, R. (2005). In S. A. Graham (Ed.), *Self-healing through visual & verbal therapy.* London: Jessica Kingsley.
Simonds, S. L. (1994). *Bridging the silence*. New York: Norton.
Singer, F. (1980). *Structuring child behavior through visual art*. Springfield, IL: Charles C. Thomas.
Sizemore, C. C. (1977). *I'm Eve*. New York: Doubleday & Company.
Skaife, S., & Huet, V. (1998). (Eds.). *Art psychotherapy in groups: Between pictures and words*. London: Routledge.
Smith, S. L. (1979). *No easy answers*. Cambridge, MA: Winthrop.
Solomon, M., & Siegel, D. (Eds.). (2003). *Healing trauma: Attachment, mind, body and brain.* New York: The Guilford Press.
Spaniol, S. E. (1990). *Organizing exhibitions of art by people with mental illness: A step-by-step manual.* Boston: Center for Psychiatric Rehabilitation, Boston University.
Spencer, L. B. (1997). *Heal abuse & trauma through art*. Springfield, IL: Charles C. Thomas.
Spiegel, D. (Ed.). (1999). *Efficacy and cost-e&ectiveness of psychotherapy.* Washington, DC: American Psychiatric Press.
Spring, D. (1993). *Shattered images*. Chicago: Magnolia Street Publishers.
Spring, D. (2001). *Image & mirage: Art therapy with dissociative clients.* Springfield, IL: Charles C. Thomas.
Spring, D. (2007). *Art in treatment: Transatlantic dialogue.* Springfield, IL: Charles C. Thomas.
St. Thomas, B. & Johnson, P. (2007). *Empowering children through art expression: Culturally sensitive ways of healing trauma and grief.* London: Jessica Kinsgley.
Steinhardt, L. (2000). *Foundation & form in Jungian sandplay.* London: Jessica Kingsley.
Stepney, S. A. (2001). *Art therapy with students at risk: Introducing art therapy into an alternative learning environment for adolescents.* Springfield, IL: Charles C. Thomas.
Stevens, A. (1986). *Withymead.* London: Coventure.
Thevoz, M. (1976). *Art brut*. New York: Skira.
Thigpen, C. H., & Cleckley, H. M. (1957). *The three faces of eve.* New York: Popular Library.
Thomas, G. V., & Silk, M. J. (1990). *An introduction to the psychology of children's drawings*. New York: New York University Press.
Thomson, M. (1989*). On art & therapy*. London: Virago.
Tinnin, L. W., & Gantt, L. (2000). *Trauma Recovery Institute manual & video, "Instinctual Truama Response."* Morgantown, WV: Gargoyle Press.
Trechsel, G. A. (Ed.). (1995). *Pictured in my mind: Contemporary American self-taught art.* Birmingham, AL: Birmingham Museum of Art, 1995.
Twitchell-Allen, D. (1958). *Twitchell-Allen three-dimensional personality test: A 1958 revised guide for administration & recording.* New York: C. H. Stoelting.
Ude-Pestel, A. (1977). *Betty: History & art of a child in therapy*. Palo Alto, CA: Science & Behavior Books.
Uhlin, D. M. (1972). *Art for exceptional children*. Dubuque, IA: William C. Brown Company.
Ulman, E., & Dachinger, P. (Eds.). (1975). *Art therapy in theory and practice.* New York: Shocken Books.
Ulman, E., Kramer, E., & Kwiatkowska, H. (1977). *Art therapy in the United States.* Craftsbury Common, VT: Art Therapy Publications.
Ulman, E., & Levy, C. (Eds.). (1981). *Art therapy viewpoints*. New York: Schocken Press.
Van Sommers, P. (1984). *Drawing and cognition.* Cambridge: Cambridge University Press.
Viola, W. (1942). *Child art & Franz Cizek* (2nd ed.). London: University of London Press.
Viorst, J. (1986). *Necessary losses: The loves, illusions, dependencies, and impossible expectations that all of us have to give up in order to grow.* New York: Simon & Schuster.
Virshup, E. (1978). *Right brain people in a left brain world.* Los Angeles, CA: Art Therapy West.
Virshup, E. (Ed.). (1993). *California art therapy trends.* Chicago, IL: Magnolia Street Publishers.
Volavkova, H. (Ed.). (1962). *I never saw another butterfly … Children's drawings and poems from Terezin concentration camp, 1942–1944.* New York: McGraw-Hill.
Wadeson, H. (1980). *Art psychotherapy*. New York: Wiley.
Wadeson, H. (2000). *Art therapy practice: Innovative approaches with diverse populations.* New York: Wiley.
Wadeson, H., Durkin, J., & Perach, D. (Eds.). (1989). *Advances in art therapy.* New York: Wiley.

Wadeson, H. W. (Ed.). (1992). *A guide to conducting art therapy research.* Mundelein, IL: American Art Therapy Association.
Wallace, E. (1990). *A queen's quest.* Santa Fe: Moon Bear.
Waller, D. (1991). *Becoming a profession: The history of art therapy in Britain 1940–82.* London: Routledge.
Waller, D. (1993). *Group interactive art therapy: Its use in training and treatment.* London: Routledge.
Waller, D. (1998). *Towards a European art therapy: Creating a profession.* Philadelphia, PA: Open University Press.
Waller, D. (1999). *Treatment of addiction: Current issues for arts therapists.* London: Routledge.
Waller, D. (Ed.). (2007). *Arts therapies & progressive illness: Nameless dread.* London: Brunner-Routledge.
Waller, D., & Gilroy, A. (Eds.). (1992). *Art therapy: A handbook.* Bristol, PA: Open University Press.
Waller, D., & Mahony, J. (Eds.). (1999). *Treatment of addiction: Current issues for arts therapies.* London: Routledge.
Waller, D., & Sibbett, C. (2005). *Art therapy and cancer care: Facing death.* Bristol, PA: Open University Press.
Wallin, D. J. (2007). *Attachment in psychotherapy.* New York: The Guilford Press.
Warren, B. (2008). *Using the creative arts in therapy and healthcare: A practical introduction* (3rd ed.). New York: Routledge.
Watkins, J. G. (1992). *Hypnoanalytic techniques.* New York: Irvington.
Watkins, M. M. (1984). (3rd ed.) *Waking dreams.* New York: Gordon & Breach.
Weaver, Rix. (1973). *The old wise woman*. New York: Putnam's, 1973.
Weiser, J. (1993). *Phototherapy techniques.* San Francisco, CA: Jossey-Bass.
Weiss, J. (1984). *Expressive therapy with elders & the disabled*. New York: Haworth.
Welsh, G. S. (1959). *Welsh figure preference test: Including the Barron-Welsch Art Scale.* New York: Consulting Psychologists Press.
Wilkinson, V. C., & Heater, S. L. (1979). *Therapeutic media & techniques of application.* New York: Van Nostrand Reinhold.
Williams, G. H., & Wood, M. M. (1977) *Developmental art therapy*. Baltimore, MD: University Park Press, 1977.
Wilson, L. (2003). *Alberto Giacometti: Myth, magic and the man.* New Haven, CT: Yale University Press.
Winner, E. (1982) *Invented worlds: The psychology of the arts.* Cambridge, MA.: Harvard University Press.
Winnicott, D. W. (1971a). *Playing and reality*. New York: Basic Books, pp. 1–25.
Winnicott, D. W. (1971b). *Therapeutic consultations in child psychiatry*. New York: Basic Books.
Winnicott, D. W. (1989). *The squiggle game*. In C. Winnicott, R. Shepherd, & M. David (Eds.). *Psychoanalytic explorations* (pp. 299–317). Cambridge, MA: Harvard University Press.
Wiseman, A. S. (1989). *Nightmare help: A guide for parents and teachers.* Berkeley, CA: Ten Speed Press.
Wohl, Agnes, & Kaufman, Bobbie. (1985). *Silent screams & hidden cries*: *A compilation and interpretation of artwork by children from violent homes.* New York: Brunner/Mazel, 1985.
World Health Organization (WHO). (1992). *International classification of diseases, 9th Revision, Clinical modification (ICD-9-CM*) (6th ed.). (Rev. NCHS, National Center for Health Statistics). Los Angeles, CA: Practice Management Information Corporation.
Wysuph, C. L. (1970). *Jackson Pollock: Psychoanalytic drawings.* New York: Horizon.
Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.
Yelen, A. R. (Ed.). (1995). *Passionate visions of the American south: Self-taught artists from 1940 to the present* (Rev. ed.). Jackson, MS: University Press of Mississippi.
Zinker, J. (1977). *Creative process in Gestalt therapy.* New York: Brunner/Mazel.

Introduction to Art Therapy: Sources & Resources

A Note to the Reader/Viewer . . . Illustrations, not Instructions

Because the book covers a great deal of ground, this DVD, which is meant to be played on a computer rather than a DVD player, is intended to illustrate rather than to instruct. In order to show a wide variety of examples, I have opted for breadth rather than depth. Another reason for the brevity of most of the film clips is to minimize the likelihood of revealing sensitive information or material about the participants.

While the majority of the illustrative clips are from unfinished film and tape materials, some are excerpts from finished works, a few of which may still be available for purchase. I have therefore included any relevant information, as well as a listing of those individuals and institutions that have generously given permission for their inclusion in the *Acknowledgments*.

About Confidentiality

Although not all of the people on this DVD are patients, it is important to note that many were, and that they agreed to be photographed for the purpose of professional education. Since this book is meant for those in the helping professions, I trust that viewers will respect the privacy of participants allowing themselves to be filmed and will maintain the same kind of confidentiality normally accorded to any clinical material.

Figures

All of the figures in the text are black and white. Those that are also available in color are on the DVD in folders for each chapter (Figures in Color) with identifying numbers.

In order to view the video files on this DVD it is necessary to download QuickTime. Here is the link for the free download:

http://www.apple.com/quicktime/download/

All of the video clips are in MPEG-4 format. All of the still images are JPEGs. Both are viewable on Mac and PC computers (i.e., they are cross-platform compatible).

Contents of the DVD

FOREWORD
- 0.1 My Life in Art Therapy

CHAPTER 1. PREVIEWS
- 1.0 Figures in Color
  - 1.3 "Our Trip to Scotland" by Randy
  - 1.5 "A Girl has Grown Long Hair & Locked Her Mommy in the Garage"
  - 1.8 "A Sad Girl" by Lori
  - 1.9 A Clay Creature's Head by Jack
  - 1.11 A Later Athlete by Jim
- 1.1 Cave Paintings
  - A. Lascaux
  - B. Lascaux
  - C. Lascaux
  - D. Lascaux
- 1.2 Animal Artists
  - A. Chimp Painting
  - B. Dolphin Painting
  - C. Elephant Painting
- 1.3 Lori in Art Therapy
- 1.4 Mrs. Lord in Art Therapy
- 1.5 Discovering Feelings Through Art
- 1.6 Art Helps Me in Times of Trauma
  - A. After Peter's Death
  - B. My Nightmare
  - C. The Scariest Dream
  - D. My Mother
  - E. My Children
- 1.7 Drawing Helps My Mourning Process
  - A. Pain
  - B. My Mother in the Hospital Bed
  - C. Mama-Breast-Love
  - D. I Love You, I Need You
  - E. Can You See?
  - F. Together Again
  - G. Screaming
  - H. Cold and Lonely
  - I. All Together
  - J. Mom – Inside Me Forever
- 1.8 Randy – A Boy with Encopresis
  - A. Zebra
  - B. Zebra & Fox
  - C. Mars & Constellations
  - D. The Art Therapist & the Martian
  - E. A Castle
  - F. School on Fire

G. Dinosaur & Volcano
H. Cover – Space Series
I. Cover – Earth Series
J. Randy Giving the Art Therapist a Gift
K. Randy Holding onto the Art Therapist's Belt
L. Woman on a Cliff
M. The Revolutionary War

1.9 Art Contains Aggression at Home
A. Ugly Drawing of Parents by Jenny
B. Family Drawing a Year Later by Jenny
C. A Girl Who Has Grown Long Hair & Locked Her Mommy in the Garage
D. The Girl Has the Key
E. Jon Painting a Monster
F. Ugly Drawing of Older Sister Nona by Jon
G. Killer Shark Devouring Bad Mother by Jon
H. Ugly Drawing of Father by Jon
I. Armed Ships by Jon
J. Fantasy Creature by Jon

1.10 Stories from the Art Therapy Studio
A. Lori Drawing
B. "A Sad Girl"
C. A Boy Puts on Soap Crayon Makeup
D. A Boy Talks into a Tape Recorder
E. A Monster Head by Jeff
F. A Volcano by Alan
G. Alan and His Torture Chamber
H. Some of Jack's Cartoon Characters
I. One of Jack's Prehistoric Creatures
J. An Early Drawing by Betty Jane
K. A Later Drawing by Betty Jane
L. Jim Drawing an Athlete
M. Jim's Growth Over Time
N. Jim as a Big Shot
O. Mrs. Lord Talking while Drawing
P. Mrs. Lord Associating to Her Drawing
Q. "Shock"
R. "Ambivalence, Dilemma, Uncertainty, Confusion"
S. Mrs. T. by Mr. T. – "The Rock of Gibraltar"
T. Mr. T. by Mrs. T. – "Always Busy"

CHAPTER 2. DEFINITIONS: WHAT IS ART THERAPY?

2.0 Figures in Color
2.11 Carla's Nightmare Monster
2.12 Participant in "Parent Play Group"

2.1 Art Therapy: What it *Is* and What it Is *Not*
A. A Psychiatrist Requests a Drawing
B. A Humorous Twist: Therapy for Art!

- 2.2 Art Therapy and Art Education
  - A. Edith Kramer Teaching Color Mixing
  - B. Mixing Skin Colors to Deal with Identity
  - C. Art Therapy Group Looks Like an Art Class
  - D. Art Assessment with a Teenage Boy
  - E. Family Art Evaluation
  - F. Boy at the W. PA School for the Deaf
  - G. Group at the Pittsburgh Center for the Arts
- 2.3 Art Therapy and Art for People with Disabilities
  - A. Art Class – Home for Crippled Children
  - B. Art Therapist with a Deaf Child in a School
  - C. Donovan, a Boy on a Ventilator
  - D. Blind Boy Masters the Trauma of 50 Operations
  - E. Mother and Son Working Together
  - F. Mothers and Children Working Side by Side
  - G. HAI Art Workshop
  - H. HAI Workshop Artist
  - I. Edith Kramer Doing an Assessment
- 2.4 Medical Art Therapy and Arts Medicine
  - A. Arts Medicine at Shands Hospital
  - B. AIDS Patient in Art Therapy
- 2.5 Room for All – Teamwork
  - A. Excerpt – Introduction to "Children & the Arts"
  - B. Elda Unger Training Free Arts Volunteers
  - C. Gloria Simoneaux of DrawBridge
  - D. About DrawBridge
- 2.6 Art Therapy and Child Therapy
  - A. Play Therapist Eliana Gil Using & Discussing Art
  - B. *My Mom & Dad Don't Live Together Anymore*
  - C. A Child Drawing in a Hospital Bed
  - D. Medical Students Offering an Art Activity
  - E. Art Therapy in a College Counseling Center
- 2.7 Art Therapy and Occupational, Recreational & Activity Therapy
  - A. Early Occupational Therapy
  - B. Excerpt from *Hands*, about a Patient in Occupational Therapy
  - C. Creative & Expressive Arts Therapy at WPIC
    1. Art Therapy
    2. Music Therapy
    3. Dance Therapy
    4. Drama Therapy
- 2.8 Others Use Art in Therapy – Robert Coles, M.D.
- 2.9 Art Therapy and Expressive Therapies
  - A. Carla's Story: Art & Drama
    1. Bars to Cage the Nightmare Monster
    2. The First Drawing of the Monster
    3. Another Nightmare Monster with Victims
    4. Carla as the Monster Attacking Me
    5. Mother & Baby Turtle

6. A Nightmare Monster in Carla's Film
7. An Excerpt from Carla's Film

B. Multimodal Groups at Pittsburgh Child Guidance Center
1. Art-Drama Therapy Group with Latency-age Boys
2. Art-Drama Therapy Group with Adolescents
3. Parent Play Training Group
4. Excerpt from "The Green Creature Within"
5. My Patient Playing Music
6. My Patient Doing a Drama
7. Ellie Irwin's Patient Doing Art

C. On Art & Movement Workshop – Mildred Lachman Chapin
D. Shaun McNiff on the Lesley Program
E. Paolo Knill on Expressive Therapy
F. Multimodal Work with Children
1. A Boy Pretends to Be a Wizard
2. A Boy Attacks with His Sword
3. A Girl Talks for Her Clay Horsie
4. Violet Oaklander Suggests Dramatizing with Clay

G. Natalie Rogers on the "Creative Connection"
H. Penny Lewis, Expressive Arts Therapist

CHAPTER 3. HISTORY

3.0 Figures in Color
3.7 Edith Kramer Doing Art Therapy at Wiltwyck
3.8 A Self-Portrait by Edith Kramer
3.11 Hanna Kwiatkowska, Family Art Therapy

3.1 Natural Beauty Is Soothing
A. Desert
B. Expanse
C. Rocks
D. Sky
E. Trees
F. Vista

3.2 Creating Comes Naturally
A. A Toddler Creates with Chalk
B. Congo the Chimp Painting
C. David Henley Paints with a Chimp
D. June's Drawing

3.3 Art for Healing Is Ancient
A. Cave Painting
B. Tibetan Mandalas

3.4 Art Therapy: An Idea Whose Time Had Come
A. Sigmund Freud, Psychoanalysis
B. Carl Gustav Jung, Analytical Psychology
C. *The Scream* by Edvard Munch (Expressionism)
D. *Self-Portrait* by Salvador Dali (Surrealism)

3.5 Psychiatric Interest in Patient Art
A. Painting by a Psychiatric Patient

- B. Patient Drawings on Toilet Paper
- C. Painting by Adolf Wolffli

3.6 Interdisciplinary Exchange
- A. Irene Jakab, M.D., Ph.D.
- B. Dr. Jakab's Book (1956; Rev. 1998)
- C. Diana Halliday

3.7 Art Brut and Outsider Art
- A. Book on Art Brut
- B. Howard Finster, Outsider Artist
- C. Jimmy Lee Sudduth, Folk Artist

3.8 Art in Diagnosis and Therapy
- A. Early use of Finger Painting at Menninger
- B. Edith Zierer with Paintings by Patients
- C. Marion Milner Interview
- D. Mary Barnes with Joseph Berke, M.D.

3.9 Therapeutic Art Education
- A. Viktor Lowenfeld with Blind Girl in Vienna
- B. Viktor Lowenfeld with Disabled Student in the U.S.
- C. Viktor Lowenfeld Lecturing at Penn State University
- D. Florence Cane Teaching a Student in NY
- E. Florence Cane's Students Doing Scribbles

3.10 WPA and the Federal Art Project
- A. Georgette Seabrooke as a Young Painter
- B. Georgette Powell in Her Art Studio
- C. "Recreation," Seabrooke's Mural in Harlem Hospital

3.11 Naumburg and Kramer
- A. Margaret Naumburg
- B. Edith Kramer
- C. Margaret Naumburg as a Young Woman
- D. Margaret Naumburg Talking about Her Work
- E. Margaret Naumburg & Exhibit of Patient Art
- F. Edith Kramer as a Young Student in Vienna
- G. Edith Kramer at Wiltwyck School
- H. Edith Kramer Talking about Her Work

3.12 Other Art Therapy Pioneers in the U.S.
- A. Elinor Ulman
- B. Ulman & Levy Lecturing
- C. Menninger Foundation
- D. Mary Huntoon
- E. Don Jones
- F. Robert Ault
- G. Charles Anderson
- H. Marge Howard
- I. Elsie Muller
- J. Irene Jakab
- K. Hanna Kwiatkowska
- L. Myra Levick

M. Felice Cohen
N. Margaret Naumburg – First AATA HLM
3.13 Art Therapy in Other Countries
A. Adrian Hill
B. Edward Adamson
C. Gilbert & Irene Champernowne
D. Marie Revai
E. Creative Arts Therapies Conference, Japan 2006
F. Bobbi Stoll in Bosnia
G. Art Therapy Workshop, India 2007
H. Art Therapy Workshop, Taiwan 2006
I. Art Therapy Conference, Thailand 2008
J. Asia Pacific Art Therapy Center Advisory Board, New York 2007
K. Workshop in Sao Paolo, Brazil 2006

CHAPTER 4. THE BASICS
4.0 Figures in Color
4.2 The Art Therapist as Teacher, Gladys Agell
4.11 A Nursing Home Patient Engaged in Creating
4.1 The Art Part
A. Things to Draw with
B. Things to Paint with
C. Things to Model & Construct with
D. Tempera Markers
E. Vija Lusebrink
F. Sandra Kagin Graves
G. Laurie Wilson
H. Arthur Robbins
I. Helen Landgarten
J. Facilitating the Creative Process
K. Observing the Creative Process
L. Robert Ault
M. Janie Rhyne
4.2 The Therapy Part
4.3 Necessary Conditions – The Framework
A. My Co-Therapist at PCGC
B. Irene Rosner-David on Collaboration at Bellevue
C. Roger Arguile Planning with Colleagues
D. Art & Speech Therapist Work Together
4.4 Doing Art Therapy – The Interface
A. Robert Coles Invites a Drawing
B. Judy Rubin Requests Family Representations
C. Vera Zilzer Observes Sequences in a Drawing
D. Natalie Rogers Helps Woman Compare Drawings
E. Moving to the Image – Carolyn Grant Fay Client
4.5 Evaluating Art Therapy – Elizabeth Layton's Story
4.6 Why Art Therapy Works
A. "It's My Fault"

B. A "Life Space" Drawing
C. A Spontaneous "Life Line" Drawing
D. Good & Evil in One Person
E. People Creating Individually
F. People Creating Jointly
G. Looking & Reflecting
H. Comparing Family Drawings
I. Art Therapy in Hospital Beds
J. Art Therapy for Trauma
K. Art-Awareness Group
L. Art Is a Natural "High"

4.7 QuickDraw – Shaun McNiff

CHAPTER 5. APPROACHES

5.0 Figures in Color
5.1 Linda Welcoming the Next Patient
5.2 Edith Wallace, Jungian
5.3 Janie Rhyne, Gestalt
5.4 Mala Betensky, Phenomenological
5.6 Ellen Roth, Behavioral
5.8 Aina Nucho, Psychocybernetic
5.9 Marcia Rosal, Cognitive-Behavioral Art Therapy
5.12 Helen Landgarten, Family Art Psychotherapy
5.15 Shaun McNiff, Expressive Therapies

5.1 Psychodynamic Approaches
A. Marion Milner – "Hands of the Living God"
B. Ainslie Meares – Australian Pioneer
C. Judy Rubin – Internal Conflict & Insight
D. Edith Kramer – Sublimation
E. Laurie Wilson – Symbolization
F. Arthur Robbins – Object Relations
G. Mildred Lachman Chapin – Self Psychology
H. Linda Welcoming the Next Patient
I. Carolyn Grant Fay on "Active Imagination"

5.2 Humanistic Approaches
A. Josef Garai – Humanistic/Holistic
B. Natalie Rogers – Person-Centered
C. Laury Rappaport – Focusing-Oriented
D. Violet Oaklander – Gestalt
E. Janie Rhyne – Gestalt Art Experience
F. Mala Betensky – Phenomenological
G. Witness Writing – Open Studio

5.3 Psycho-Educational Approaches
A. Rawley Silver
B. Aina Nucho
C. Marcia Rosal & Congressman
D. Ann Sayre Wiseman – "Nightmare Help"
E. Viktor Lowenfeld Writing

F. Donald Uhlin
G. Susan Aach-Feldman
H. Carole Kunkle-Miller
I. Frances Anderson & Student
J. Robert Ault on "Process-Centered Art Therapy"

5.4 Systemic Approaches
A. Hanna Kwiatkowska
B. Early Family Art Evaluation at NIMH
C. Later Family Art Evaluation at a Clinic
D. Helen Landgarten with Father & Daughter
E. Shirley Riley with Mother & Daughter
F. Harriet Wadeson – Couple Art Evaluation
G. Lucille Proulx – Parent-Child Dyad Art Therapy
H. "Our House" by John & Mother
I. John & Mother on Opposite Sides of Easel
J. John's Portrait of His Mother
K. Mother's Portrait of John
L. Edward Adamson in His Studio
M. Cliff Joseph in an Art Therapy Group
N. Early Tight Drawing by Don
O. Don's Wounded Boy Sculpture
P. One of Don's Messy Paintings
Q. Don's Gift to His Therapist at Termination

5.5 Art/Image-Based Approaches
A. Pat Allen
B. Shaun McNiff
C. Cathy Moon
D. Don Seiden

5.6 Spiritual Approaches
A. Ellen Horovitz
B. Lynn Kapitan

5.7 Integrative Approaches
A. Elinor Ulman
B. Harriet Wadeson
C. Shaun McNiff
D. David Henley
E. Natalie Rogers

5.8 Theory, Technique, and Art Therapy
A. Margaret Naumburg
B. Edith Kramer
C. Robert Ault – 3 Approaches to Art Therapy

CHAPTER 6. ASSESSMENT

6.0 Figures in Color
6.1 Joan Kellogg, MARI
6.2 Doris Arrington, VPT
6.6 Person by Jimmy
6.7 Self-Portrait by Jimmy

6.8 Linda Gantt, PPAT & FEATS
6.9 Barry Cohen, DDS
6.12 Jimmy's Pride in His Drawings
6.1 Bernard I. Levy – Projective Hypothesis
6.2 Carole Cox – MARI Test
6.3 Elinor Ulman – Scribble Drawing
6.4 Person Picking an Apple from a Tree (PPAT)
A. Major Depression
1. Chronic Depression
2. Suicide Attempt
B. Schizophrenia
1. Hebephrenic
2. Paranoid
3. Schizo-Affective
C. Dementia
1. Alzheimer's Disease
2. Dementia
D. Examples Over Time
1. 35F, 1st Admission
2. 2nd Admission, 6 Months Later
3. 3rd Admission, 2 Years Later
4. 51M, On Admission
5. One Week Later
E. Sample FEATS Scales (Formal Elements Art Therapy Scale)
1. Scale #8 – Problem-Solving
2. Scale #11 – Line Quality
6.5 Harriet Wadeson Inviting Modifications
6.6 Charles Anderson Teaching the Sociogram
6.7 Draw-a-Person and Self-Portrait in Assessment
A. Jimmy's Person Drawing: A Clown
B. Jimmy's Self-Portrait: Legs Lost in Grass
6.8 Assessing Change in Blind Children
A. Pre-Program Assessment – Ricky
B. Pre-Program Assessment – Peter
C. Post-Program Assessment – Karen
D. Post-Program Assessment – Terry
E. Post-Program Interview – Bill
F. Post-Program Interview – Peter
6.9 Edith Kramer's 3 Media Assessment
6.10 Judy Rubin's Unstructured Evalutation
A. A Tree
B. "Fred"
C. A Scribble Drawing Helps
D. Excerpts from Lisa's Session
E. Excerpts from Andy's Session
6.11 Edith Zierer with a Patient
6.12 Assessment Batteries: Individuals
A. UPAP – Elinor Ulman & 2 Young Adults

B. UPAP – Elinor Ulman & 2 Adolescents
C. UPAP – Gladys Agell & an Adult
D. DDS – Barry Cohen & a Woman
E. DDS – Anne Mills & an Adult
F. Mala Betensky – Diagnostic Task
G. LECATA – Craig Siegel & a Child
H. BATSE – Nancy Gerber & a Young Adult
I. BATA – Ellen Horovitz & a Young Adult

6.13 Assessment Batteries: Families
A. Kwiatkowska FAE – Patti Rossiter & Mari Fleming
1. A Picture of the Family
2. Abstract Family Portrait
3. Joint Family Picture
B. Rubin – Art Evaluation
1. Scribble Drawing
2. Family Representation
3. Family Mural
C. Landgarten – Father/Daughter Task
D. Wadeson – Couple Art Assessment
1. Joint Drawing without Talking
2. DSelf-Portrait + Modifications
3. Discussing Modifications by Spouse

6.14 Silver Drawing Test of Cognition and Emotion
A. Ellen Horovitz & a Deaf Adolescent
B. Peg Dunn-Snow & a Young boy

CHAPTER 7. TECHNIQUE(S)

7.0 Figures in Color
7.1 James Consoli, Psychimagery
7.3 My Painting of Ellen, an Elective Mute
7.4 Mildred Lachman Chapin Drawing with a Client
7.5 A Child Drawing in the Hospital
7.6 Sandra Kagin Graves, Media Dimensions Variables
7.7 Vija Lusebrink, Expressive Therapies Continuum
7.10 Filming in an Art-Drama Therapy Group
7.11 Isaac Dramatizing in Art Therapy
7.12 Isaac's Head & Victim on Display

7.1 Evoking Expression
A. Janie Rhyne – Group Warm-up
B. Stimulus Drawings by Rawley Silver
C. Using Magazine Photographs
1. Shirley Riley
2. Maxine Junge
D. Using Art Reproductions – Trude Wertheim-Cahen
E. Using a String Dipped in Ink – Evelyn Virshup
F. Using the Non-Dominant Hand – Natalie Rogers
G. Contour Drawing Is Therapeutic
1. Elizabeth Layton Cures Depression

2. Robert Ault Uses Contour in Therapy
3. Robert Ault's Book on Contour Drawing

H. Regressive Media Help Deal with Shame
1. "Roads"
2. "Like Hell, a Storm with Lightning & Turmoil"

I. Psychimagery for Abuse – Jim Consoli

J. Free Association in Art Imagery

K. Moving to the Image

7.2 Facilitating Expression

A. Shirley Riley Helps Alzheimer's Patient

B. Bruce Moon Draws with a Student

C. Art Therapists Draw Patient Portraits
1. Vera Zilzer
2. Alice Karamanol

D. Irene Rosner Helps Eddie
1. Irene Follows Eddie's Instructions
2. Eddie Paints with Irene's Assistance

E. Drawing Along with a Family

F. Mildred Lachman Chapin Draws with a Patient

G. Creative Drawing Workbooks
1. Lucia Cappachione
2. *The Creative Journal*
3. *Managing Traumatic Stress Through Art*
4. *Expressions of Healing*
5. *Drawing and Coloring for Your Life*
6. *When Someone Very Special Dies*
7. *My Mom and Dad Don't Live Together Anymore*

H. Modeling with Eyes Closed

7.3 Specific Tasks for a Family

A. Main Problem by Father

B. Main Problem by Mother

C. Mother's Wish

D. Father's Wish

E. Tim Leaves Family Group

F. Father Joins Tim

G. Father Rejoins the Females

H. Tim Adds Something to the Picture

7.4 Sandplay

A. Dora Kalff with a Child

B. Carolyn Grant Fay with an Adult

7.5 Hypnosis and Meditation

A. Hypno-Art Therapy – Karen Clark-Schock

B. Relaxation – Natalie Rogers

7.6 Phototherapy

A. Bringing in Family Photos of Kittens

B. Robert Wolf

C. Polaroid Photos in Cartoons
1. Anger at Mothers

2. Monster Shoots Therapist
3. Plan to Knock-off Therapist
D. Photo-Art Therapy
E. Judy Weiser
7.7 Film & Animation
A. Setting Up for Animation
B. Doing Animation
C. Filming Animation
D. "Dreams so Real" Excerpt
E. Using Films to Review Therapy
F. "Green Creature Within" Excerpt
7.8 Video Art Therapy
7.9 Art and Film Therapy – Isaac
A. Isaac Drawing as a Child
B. Isaac Dramatizing with Clay
C. Isaac's Head & Victim
D. Isaac's Claymation Monster
7.10 Multimodal Expressive Therapy
A. Art Therapy & Psychodrama
B. Art-Drama Therapy Group
C. Parent Play Training Group

CHAPTER 8. PEOPLE WE SERVE
8.0 Figures in Color
8.2 Mary Ann Hayden-Shaughnessy
8.3 Ellen's First Drawings of Her Creature
8.4 A Later Drawing by Ellen of Her Creature
8.6 Amy in Art & Play Therapy
8.8 One of Sam's Abstract Sculptures
8.9 One of Sam's Figurative Paintings
8.10 A Woman Beginning a Self-Portrait
8.11 A Man Working with Clay
8.12 One of Sally's Powerful Paintings
8.16 An Older Man Painting in a Hospital
8.17 "I'm Into Art Therapy" – Elizabeth Layton
8.1 Ellen – An Elective Mute
A. My Painting of Ellen
B. Drawing Dialogue
C. Ellen's Drawing After a 6-week Interruption
D. Ellen's 1st Enlargement of Her Creature 1 Week Later
E. My Picture of a Sad/Angry Girl
F. Ellen's Creature, More Color
G. Ellen's Creature, Different Hairdo
H. One of the Last Creatures
8.2 Billy Battles Bereavement
A. A Child at the Sand Table – Ellie Irwin
B. Billy Pretending to "Be a Daddy"

8.3 Art & Play Therapy for Anxious Amy
A. Amy & Clay Figures
B. Amy Drawing on a Chalkboard
C. Amy & Her King/Princess Drawing
8.4 Art Therapy for Painfully Shy Lucy
A. One of Lucy's Tiny Clay Figures
B. One of Lucy's Expressive Paintings
8.5 Sam – A Schizoid Teenager
A. One of Sam's Paintings
B. Sam's Growth Over Time
C. "View from My Window"
8.6 Art in Diagnosis and Therapy with Sally
A. One of Sally's Expressive Drawings
B. One of Sally's Poignant Paintings
8.7 Unresolved Grief – Oliver
A. Boy Looking Out a Window
B. Aloof "Superwoman"
8.8 It's Never Too Late – Hannah
A. A Sad Dog
B. A Monster Head Similar to Hannah's
8.9 The Story of Elizabeth Layton
8.10 "Beyond Words" Excerpts
8.11 Art and Art Therapy at the Hebrew Home
8.12 Self-Taught Artists
A. Jimmy Lee Sudduth
B. Howard Finster

CHAPTER 9. PROBLEMS WE ADDRESSS

9.0 Figures in Color
9.3 The Tortoise Shell Family – Dorothy
9.5 Larry and the Art Therapist
9.7 Virginia Minar
9.9 Donald Uhlin, Developmental Art Therapy
9.11 One of Lila's Body Drawings
9.12 Lila's Enmeshed Family Drawing
9.13 "Holding Environment" by Elaine
9.14 "Therapy" by Elaine
9.1 William Kurelek on "The Maze"
9.2 Karen – A Story of Creative Coping
A. Karen Painting
B. Painting a Spontaneous Mandala
C. Karen's Image of Attachment
D. Karen Is Proud of Her Artwork
E. Karen Dancing in Her Christmas Video
9.3 Dorothy – Childhood Schizophrenia
A. A Bird
B. Bird Painting
C. Another Bird

D. Bird Feeding Babies
E. Free Painting
F. Monster
G. The Eagle & the Dummy
H. Destructive Eagle & Victim
I. Painted Bird
J. Activities on the Unit
K. The Kids on the Unit
L. Going on a Picnic
M. All the Kids
N. Throwing Doll Away
O. A Cat
P. Another Cat
Q. My Best Cat Costume
R. Watching in a Cat Costume
S. Mrs. Rubin
T. Mrs. Rubin Having a Baby
U. Mrs. Rubin Attacked for Being Bad
V. The Tortoise Shell Family

9.4 Marijke Rutten-Sarris and 2 Autistic Boys
9.5 Kitty – High-Functioning Autism
A. Cover – "Wonder Woman"
B. First Page – "Wonder Woman"
C. Book – "In the Bubble"
D. "They Popped the Bubble"
9.6 Jane – Partially Sighted
9.7 Larry – Totally Blind
A. Larry Using Clay
B. Two of Larry's Clay Rockets
C. Going to the Doctor
D. Going to the Dentist
E. Giving/Getting a Shot
F. Larry Playing a Gong
G. Larry with a Big Finger
H. Larry Singing
I. Larry & His Mother
J. Larry Blowing into the Microphone
K. Larry & the Therapist
9.8 History of Art Therapy for Those with Disabilities
A. Art Program – Home for Crippled Children
B. About Viktor Lowenfeld
C. Creative Growth
D. Dwight Mackintosh
E. Judith Scott
F. Sally Smith – The Lab School
G. Virginia Minar
H. Janet Bush
I. Frances Anderson

J. Rawley Silver
K. Donald Uhlin
L. Edith Kramer
M. David Henley
N. Very Special Arts Festival
O. Family by Blind Girl's Brother
P. Larry & Mother Painting
Q. Excerpt from Film by Teens with Cleft Palates

9.9 Problems Helped by Art Therapy
A. Art Therapy at the Renfrew Center
B. All Head, No Heart
C. Starving Man
D. NoBody #1
E. NoBody #2
F. Lila's Enmeshed Family
G. Women in Recovery on Art Therapy
H. Amelia about Her Swans
I. Sexual Abuse Image
J. Physical Abuse Image
K. Image – "Courage! Together We Heal!"
L. Treating Dissociative Identity Disorder
M. Viktor Lowenfeld Speaking

9.10 The Story of Elaine
A. Family Drawing – Age 4
B. Memory of Traumatic Enemas
C. "No!" – A Protest Painting
D. A Sculpted Painting – Toilet Bowl
E. A Painted Tree
F. Face/Anus Fusion Painting
G. Out of the Fire
H. A Joyous Creation
I. An Image Found in the Clay
J. Another Emergent Image
K. Depression Is a Prison
L. "Holding Environment"
M. Elaine's Artwork on Display
N. Baby in the Womb
O. The Baby
P. Mother & Child
Q. A Clay Dyad
R. "Therapy"

CHAPTER 10. PLACES WE PRACTICE

10.0 Figures in Color
10.4 A Stutterer Relaxes Using Finger Paint
10.5 Jerry Making a Wire Sculpture
10.7 Irene Rosner at Bellevue Hospital
10.8 "My Fighters: The Swordsmen" (T-Cells)

10.11 "A Bird's Gonna Knock Another One Off the Nest!"
10.12 "Endless Easel" – Community Arts Festival
10.1 Medical Art Therapy
A. Doctor Studies Patient's Art
B. Frida Kahlo's Diary
C. Art Studio at MetroHealth
D. Burn Victim in Art Therapy
E. Stroke Victim in Art Class
F. Irene Rosner-David – Art Therapy at Bellevue
G. Susie: Early Alzheimer's
H. Susie: Later Alzheimer's
I. Eddie Draws & Talks about His Diabetes
J. Getting a Transfusion
K. Draw Your Asthma as a Creature
L. Jerry's First Plasticine Head
M. Jerry's Second Clay Head
N. Jerry's Head of His Father
O. Jerry Making a Wire Sculpture
10.2 Art Therapy in Trauma and Rehabilitation
A. Mickie McGraw & Patient in the Art Studio
B. Frida Kahlo Painting in Bed
C. Irene Rosner Helping Eddie Paint
10.3 Art as Therapy in Healing
A. Suzanne Lovell Describes Her Healing Process
B. Darcy Lynn on Her Lymphoma Art
C. Wendy Miller Discusses Darcy Lynn's Art
D. Transplant Patients Describe Their Artwork
10.4 Art Therapy for Terminal Illness
A. AIDS Patient Describes His Art Therapy
B. Sue Aach Working with Blind Children
C. "What's Happening Inside: Visualizing the Best"
D. "My Fighters: the Swordsmen"
E. "The Narrow Path: An Odds-Beater on a Sturdy Ship"
10.5 Art Therapy for Bereavement
A. My Mother Sculpting My Father
B. Support Group – Paula Schaefer
C. Multimodal Therapy – Barbara McIntyre
D. Support Group – Marge Heegaard
E. Boy Whose Mother Died – Sandra Graves
F. Christopher's Flag – "Trouble"
G. Other Side of the Flag & Weapons
H. "A Dog"
I. "A Person Falls Off a Road"
10.6 Art as Therapy in Times of Crisis
A. Edith Kramer on Friedl Dicker-Brandeis
B. Child Art from Terezin
1. "I Never Saw Another Butterfly"

2. Nightmares – Horrors of the Camp
3. The Seder – A Happy Memory

C. Adult Art from Terezin
1. Transport
2. Execution
3. Prisoners
4. March

D. Painting by Charlotte Salomon
E. Israeli Child's Drawing
F. Artist Did Portraits of 9/11 Victims
G. Logbooks Helped POWs in WWII
H. Art by Hiroshima Survivors 30 Years Later
I. Art by Vietnam Veterans
J. Drawing by Hurricane Katrina Survivor
K. Fires & Looting – 1968 D.C. Riots
L. Free Arts for Abused Children
M. Jackie in Art Therapy
N. "Dr. Rubin's Ugly Face"
O. Warning Sign on My Office Door
P. Jackie's Goodbye Valentine
Q. Open Studio for the Homeless
R. Using Photos to Deal with Traumatic Memories
S. WPA Mural in Harlem Hospital
T. About "Children & the Arts"
U. About "We'll Show You What We're Gonna Do!"
V. Prison Art Program by Museum Educator
W. Prison Art Program by Theater Artist

10.7 Art as Therapy for Wellness
A. The Art Lady Visits Mister Rogers
B. Art Awareness Training Group at PCGC
C. Parent Play Training Group at PCGC
D. A Bird Knocking Another One Off the Nest
E. Three Rivers Arts Festival
F. Parent Art Workshop at a School
G. Mother-Child Art Group in a Church
H. Family Art Workshop in a School
I. Animated Filmmaking in a Preschool
J. Janet Bush & Individual Student
K. Alice Karamanol & Class
L. Cane School of Art
M. Robert Ault & Student
N. Janie Rhyne & Growth Group

CHAPTER 11. PROFESSIONAL ISSUES

11.0 Figures in Color
11.1 Drawing After a Dental Visit
11.2 A Picture from Claire's Talking Book
11.7 A Blind Girl Examines Wood Sculpture

11.8 A Blindfolded Girl Compares Two Sculptures
11.9 A Partially Sighted Boy Explores a Sculpture
11.10 Cliff Joseph, *Art Therapy & the Third World*
11.13 Senator Clinton Viewing Client Art

11.1 Claire
- A. After Going to the Denist
- B. Claire in a Drama
- C. Doctor & Nurse – Talking Book

11.2 Storing and Reviewing the Art

11.3 Phenomenological Research on a "Tactile Aesthetic"
- A. Sculpture by Blind Child
- B. Sculpture by Partially Sighted Child
- C. Sculpture by Sighted Child
- D. Blind Judge Responds
- E. Blind Judge Compares
- F. Partially Sighted Judge with Blindfold
- G. Partially Sighted Judge Responds
- H. Sighted Judge Responds
- I. Sighted Judge with Blindfold Compares

11.4 Multicultural Competence in Art Therapy
- A. Christine Wang
- B. Lucille Venture
- C. Cliff Joseph
- D. *Art Therapy & the Third World*
- E. Georgette Powell
- F. Charles Anderson
- G. Sarah McGee
- H. Gwen McPhaul Short
- I. Anna Hiscox
- J. Cheryl Doby-Copeland
- K. Charlotte Boston
- L. Stella Stepney

11.5 Political Action and Networks
- A. Edith Kramer & Eleanor Roosevelt
- B. Art Exhibit, Capitol Rotunda 2004
- C. Senator Clinton & New York Patients Artwork
- D. Senator Clinton Viewing Client Artwork
- E. *Congressional Record* Statement
- F. Presidents of NCCATA Associations
- G. Paula Howie & Peg Dunn-Snow, AATA
- H. Laura Greenstone, NCCATA Chair

11.6 Political Action and Networks
- A. First NIMH Bibliography – 1974
- B. Second NIMH Bibliography – 1981
- C. "Looking for Me" Excerpts
- D. "Playing & Pretending" Excerpts
- E. "We'll Show You What We're Gonna Do!" Excerpts

CHAPTER 12. WHAT NEXT?

12.0 Figures in Color
- 12.1 *Art Therapy Has Many Faces* Original Cover Image
- 12.2 Art Therapy in a Prison
- 12.3 Art Therapy in a School
- 12.4 Art Therapy in a Clinic
- 12.5 Art Therapy in a Hospital
- 12.6 Describing Drawing to Child Psychiatrist
- 12.7 Computer Art Therapy

12.1 *Art Therapy Has Many Faces*
- A. Introduction
- B. Excerpts

12.2 Art Therapists as Artists – QuickDraw

12.3 Handouts
- A. Handouts for Teachers
- B. Handouts for Therapists

Index

Note: Page numbers with "n" after them indicate a note. Page number in **bold** refer to figures.

A

Abandonment, 157
Abstraction to representation, 177–178
Achromatic, 124
Active imagination, 98–99, 100
Active Imagination, 150
Acutely psychotic states, 167
Acute obsessional depression, 102
Adaptive approach, 204
  Psycho-educational approaches, 107
Addiction rehabilitation program, 30, 36
A Diary of Pictures (Salomon), 229
Adjunctive therapist, 59
Adlerian approach, 100–101
Adlerian "social clubs", 64, 111
Adolescents, 174–176
  with anorexia, 207
  anxiety, 169
  art & drama therapy for depressed, 14–16
  art and creative modalities, 46
  and art awareness, 89
  Art Awareness groups, 235
  art-drama groups, 44
  arts enrichment program for alienated, 36
  and art therapy, 24, 172
  art therapy diagnostics, 137
  Asperger's syndrome, 199
  bravery and creative coping, 191–194
  and death, 182, 227
  disturbed, 116
  Draw from Imagination, 140
  and expressive modalities, 42
  fantasies, 176
  and fears, 87, 176
  and film, 206
  helping power of art, 2
  interpersonal information and art, 139
  motivational techniques, 150
  multimodal use of expression, 101
  oedipal wishes, 110
  phenomenology, 102
  pictorial stimuli, 147
  Polaroid photography, 159
  with schizophrenia, 109, 176–179
  shy, 135, 176
  slides and films, 160, 161
  sullen, 135
Adolescent Window Triptych, 137
Adult Art Therapy (Landgarten), 180
Adults, 179–180
  abandonment, 157
  addiction rehabilitation program, 30, 36
  aging process, 185
  alcoholic, 169
  Alzheimer's disease, 150, 187, 188, 218
  anxiety, 87, 110, 148
  anxiously overinvolved mother, 198
  art and drama therapy, 30
  art in diagnosis and therapy, 180–181
  cerebral palsied, 202
  and clay, 212
  creative art activities, 238
  and creative process, 184, 213
  and death, 227
  dementia, 188
  depression, 17, 147–148, 184, 210

elective mute, 169
existential therapy, 103
and fears, 162
film, photograph, and art with ghetto, 234
and images of spouse, 19–21
loss of loved ones, 228
marriage stress, 158
multimodal group, 44
and music, 187
mutual resentment, 157
and pain, 18, 22
Parent Play, 235
perinatal death, 227
polio, 204
psychotic regression, 180
rationalization in verbal psychotherapy, 16
refugee, 233
retarded, 199
and saying goodbye, 23–24
self-definition, 186
self-destructive behaviors, 181
self-esteem, 209
self-help materials, 153
sense of Self, 186
sequential graphic Gestalt, 149
sexual abuse, 138
and shame, 148
and suicide, 172, 210
support groups, 206
therapy and older, 184
unresolved grief, 181–183
verbal therapy, 22
Aesthetic goal, 51
Aesthetics, 113
A Favorite Kind of Day (AFKD), 136
Age of virtual reality, 273–274
Aggression, 7, 12, 16, 195
Aggressive/regressive phase, 113
Aging process, 185
AIDS, 35, 159, 223, 225, 226
Alcoholic, 169
Allan Memorial Institute (Montreal), 66
A Look at Medical Art Therapy (Kahn), 223
Alternative or complementary medicine, 224, 225
Alternative Therapies in Health & Medicine, 225
Alzheimer's disease, 35, 150, 187, 188, 218
American Art Therapy Association (AATA), 277
annual conference attendance, 263
Art Committee, 249
art therapists surveyed, 128
Art Therapy and the Third World, 256
art therapy assessment, 141–142
Art Therapy: Beginnings, xv
art therapy defined, 47
art therapy education, 241, 245, 249–250, 263
Art Therapy Outcome & Single Subject Studies, 83
Assembly of Affiliate Societies, 259
Beyond Words: Art Therapy for Older Adults, xvi
cognitive approach to therapy, 93, 105
Education Standards, 250
Ethical Principles for Art Therapists, 252, 253
formation of, 62
funded studies, publications, and conferences, 205
Guidelines, 250
location of, 277
medical art therapy, 218
and political activity, 258
posttraumatic stress disorder (PTSD), 86
publications of, 265, 279
public awareness of art therapy, 260
slogan proposed, 217
University of Louisville meeting, 63–64
Using Art in Trauma Recovery With Children, 232
vision of 21st century art therapist, 270–271
American Association for the Study of Mental Imagery, 105, 148
American Association of State Counseling Boards (AASCB), 260
American Counseling Association (ACA), 41
American Institute of Medical Education, 53
American Journal of Art Therapy, 142, 265
American Nurses Foundation, 219
American Psychiatric Association (APA), 75, 260
American Psychological Association (APA), 38, 41, 154
American Society for Psychopathology of Expression (ASPE), 52, 62, 266, 277
Amyotrophic lateral sclerosis (ALS), 224
Analytical Art Psychotherapy in Theory & Practice (Schaverien), 99
Analytical psychotherapy orientation, 99
Analytic orientation, 97
Analytic therapy, 97, 99
Analytic thinking, 96–97
Anger, 173, 232
Anger in drama, 15, 42
Anger management, 215
Animated films, 237
Anna Shafer & Her Art
Films, 186
Anorexia, 207
Anthropology, 116
Anthroposophy, 114
Anxiety
adolescents, 169
adults, 87, 110, 148
children, 11–12, 13, 110
Anxiously overinvolved mother, 198
ANZAT Journal (Australia/New Zealand), 265
Aphasic, 1

Apprenticeships/courses/training programs, 245–246
Approaches to Art Therapy (Rubin), 17, 95, 96, 99, 100–101, 102, 103, 104, 106, 107, 109, 112, 115, 116, 117, 271
Archaic, 113
Archeology, 116
Archetypes, 98, 100
Art
  aesthetic goal, 51
  and aggression at home, 6–7
  analyses of, 84–85
  animated films, 237
  artists in hospitals, 56–57
  assessment, 1, 24, 31, 54, 85
  as assessment tool, 58
  automatic drawing, 102
  back to basics, 92–93
  cartoon drawings, 153
  as central modality in therapy, 47
  ceramics, 209
  children, 2, 5–6, 41, 272
  in child therapy, 272
  classification for using materials, 150
  clay, 115, 127, 150, 154, 169, 177
  cognitive aspects of, 105
  communication, 21, 167
  contour drawings, 147, 148
  crayons, 141, 147
  create with art media, 69
  creative expression, 37, 50, 87–88, 216
  and creative modalities, 46
  creative work blocks, 183
  decoding symbolic messages, 134
  defined, 25
  and destructive urges, 90–91
  and diagnosis, 119
  diagnosis and assessment tool, 142
  in diagnosis and therapy, 53–54, 180–181
  dissociative identity disorder (DID), 214
  and divorce, 9–11
  and drama, 161
  drama and depression, 14–16
  and drama modalities, 199, 201–202, 221
  and drama therapy, 30
  and drama therapy for depressed adolescents, 14–16
  drawing and painting, 61, 96, 114, 121, 151
  drawing dialogues, 151, 170
  drawing tests, 122
  drawing themes, 124
  drawing types, 137
  element of speed, 148
  enrichment program for alienated adolescents, 36
  express feelings/fantasies, 192
  Expressionism and Surrealism, 51, 55
  expression of human spirit, 226
  fantasy creatures, 7, 13, 15
  feeling or thinking, 1, 2, 3, 11, 18–19
  and film therapy, 161–162
  finger paints, 127, 148
  flexible and versatile, 89
  free association, 149, 227
  Free Flow Technique, 147
  gesture drawings, 147
  goals of, 28, 35
  graphic materials, 127
  guided imagery with drawing, 149
  for healing ancient and universal, 50–51
  healing power of, 26, 34, 35, 69, 118, 274–275
  helping, 1
  Human Figure drawing, 124
  ideas and feelings, 1, 14, 87
  improves health/prevents illness, 187
  internal psychological integration, 88
  involves whole person, 85
  is self-initiated, 223
  joint nonverbal drawing, 151
  line drawings, 120
  mandala drawing, 120, 192
  and marital therapy, 19–21
  in medical assessment, 218–220
  medium and style, 22
  memories, 86
  and mind and body wounds, 209
  modes of intervention, 85
  and mourning, 5
  naive or primitive, 53
  negative ideas and feelings, 86
  normalizes psychotherapy, 89
  and occupational therapy, 40
  and older adults, 187
  and organic impairment, 218
  painful reality, 21
  for people with disabilities, 31–35
  photo collage, 140–141, 147
  photographs, 229–230
  pictorial storybooks, 198
  and play therapy, 174
  pleasure vs therapy, 30
  process in evaluation, 84–85
  product elements, 73–74
  product helpful presence, 88–89
  product in evaluation, 84
  psychiatric interest in patient, 51–52
  psychology of, 47
  and psychopathology, 125–126
  psychotic boy and reality, 5–6
  refer to all creative modalities, 47
  and refugee children, 59, 229
  sandplay, 99
  as scapegoat, 116
  scribble drawing, 135, 147, 149, 155, 186, 228

self-development, 238
self-portrait, 186
self-taught artist, 188
self-therapy, 230, 235
sensorimotor aspects of working in, 221
and sick children, 99
and spiritual health, 90–91
stimulus drawings, 147
symbolic expression of feelings, 199–200
symbolic speech, 58, 73
as talisman, 116
technological developments, 71
tempera markers, 71
therapeutic benefits of, 27, 89, 92
therapeutic power of, 2, 5–6, 23, 34, 36, 187
therapeutic process, 60
and therapy synthesis, 118
thinking is visual, 85–86
transitional object, 202, 214
and trauma, 3–5
trauma survivors, 37
understanding, 1, 26, 74
universal language, 233
vs. verbal psychotherapy, 88
vs. verbal therapy, 84
and verbal therapy, 85
visual stimulus, 119
working with groups, 115
writing, and reality, 21–24
Art & Regeneration (Petrie), 56
Art & Soul (Moon), 114
Art activity goal, 155
Art and drama therapy groups, 234
Art as a Spiritual Path (Allen), 114
Art as Experience (Dewey), 85
Art as Medicine (McNiff), 92, 113
Art as Therapy (Dalley), 266
Art as therapy approach, 66, 115
Art Awareness groups, 89, 235, 237
Art-Based Research (McNiff), 83
Art batteries, 136–137, 139
Art behaviors, 130
Art Brut, 53
Art-centered theories, 113
Art classes, 238
Art Committee, 249
Art counseling, 38–39
Art-drama groups, 44
Art-drama therapy, 160
Art education
art therapy, 28–30, 31
copying and completion, 121
therapeutic aspects of, 37, 54–56
Art experience, 29–30
Art expression, 121, 127, 235
Art for assessment, 31
Art for Life, 225, 275
Artful Therapy (Rubin), 41, 271, 272
Art/image-based approaches, 113
Art Institute of Chicago, 246
Art Is a Spiritual Path (Allen), 92
Art Is a Way of Knowing (Allen), 92, 113
Artistic development studies, 127–128
Artistic interventions, 150–153
Artistic product value, 73
Artistic technique, sources, 165
Artist in Each of Us (Cane), 56
Artist or therapist, 274
Artists, 183
Artist-self, 151, 152, 153
Artists in hospitals, 56–57
Artist's Way (Cameron), 154
Art-making, 91
Art materials, 70–71, 173
Artmobile, 209
Artobiography (Seiden), 113
Art of Art Therapy (Rubin), 69, 78, 266
Art process, 78–79, 84–85
Art product, 88–89, 129–130
Art psychotherapy, 66, 115, 274
Art Psychotherapy, 44, 95, 125, 265
Art reproductions, 147
Arts as Therapy for Children, 36
Art sessions for children, 30
Arts in Psychotherapy, 44, 265
Arts medicine, 34–35, 93, 225, 267
Art Studio, 218
Art teachers, 28
Art therapists
AIDS, 35
Alzheimer's disease, 35
art activity goal, 155
artistic technique, sources of, 165
artist or therapist, 274
artist-self, 151, 152, 153
and art process, 78–79
art reproductions, 147
art therapy assessment, 138
assess and treat, 31
basic beliefs shared by, 69
basic principles, 80
Board Certified (ATR-BC), 250
British vs. United States, 97
common ground of art, 113
conducts assessment, 29
couples and drawing, 124, 139
diagnostic art evaluation, 135
diagnostic art interviews, 134
as diagnosticians, 128–129
and diverse viewpoints, 83
and dying patient, 225–226
elements at disposal, 155–156
evoking and facilitating expression, 78
family art evaluation, 29

formulaic approaches, 141
goals of, 117, 165
graphic language, 141
group art therapy, 29
has much to share, 271–273
and human psychology, 74
identify graphic clues, 125
individual differences, 70–71
invisible, 28
is theory necessary, 117–118
knowing materials, 69–70
knowing the creative process, 72
legal and ethical issues, 252
media arts, 160
multicultural sensitivity, 256
multiple paths, 95–96
and new media, 71
phenomenological understanding of patient's experience, 126
planning and evaluation, 81
and political realities, 258
pragmatic, 117
predictions of past and present, 270–271
primary-process image-talk, 168
projective drawings, 128, 137
and psychodynamics, 74
psychology, 83, 118, 244
psychotherapy, 35, 75
remediate psychological problems, 35
role and work setting, 216
selective eclecticism, 117
self-expression, 37
setting the stage, 78
shut out by patient, 198
stroke damage and tasks, 137–138
surveyed, 128
theories of personality/psychological functioning, 75
as theorists, 116–117
vs. therapeutic art activities, 26
therapeutic dyad, 75–76
therapeutic process, 146
Third World Committee, 256
training and education, 27–28, 35, 118
understanding/analyzing materials, 71–72
understanding therapy, 76
unspoken perspective, 117
visual arts, 45
working artistically, 79–80
Art therapy
adolescents, 24, 172
age of virtual reality, 273–274
and anxiety, 11–12
anxiety and security, 12–14
and art counseling, 38–39
and art education, 28–30
vs. art education, 31
and art experience, 29–30
art for people with disabilities, 31–35
and arts medicine, 34–35
Asian, 67
assessment, 138, 141–142
assessment in planning/evaluation, 81
basic elements of, 69
with blind children, 83, 204, 222
as a career, 266–267
children, 172, 176
and child therapy, 37–39
choosing a multimodal approach, 46–47
common modalities in, 158
component of, 74
contributors of, 57–60
creative process, 84
creativity and madness, 53
defined, 26–27, 47, 58
and depression, 16–19
development abroad, 67
development of, 68
diagnostics, 137
discipline of, 57
and drawing, 41
education, 241, 245, 249–250, 260, 263
educational aspects of, 37
evaluating, 81–83
expressive art therapy, 42–43
faces of, 1
family art evaluation, 77
and grief, 11
growth of, 51
ideas and feelings, 3
individual, 1
interface, 78–80
intervention, 83
knowing artistic products, 73–74
learning experiences, 7–9
material in, 70
in medical trauma settings, 222n1
mixing modalities in treatment, 43–44
new discipline, 25
and occupational, recreation, and activity therapy, 39–40
in other countries, 64–67
other pioneers in United States, 61–64
pain, 3
and patient risk, 215–216
primary goal therapy, 27
process of, 24
psychotherapy, 40–42
rational for, 85
related service, 204
research, 83–85
selecting patients for, 80
sharing and collaborating, 44–45
sources of, 49–51

steps for, 145–146
symbolic communication, 25
symbolic control, 3
and talented teenager, 14
teamwork, 35–37
theoretical approaches, 24
and tragedy, 22
trailblazers, 61
training programs, 44–45, 101
and trauma, 41–42
verbal psychotherapy, 47
vignettes, 1–7, 7–24
what it is/is not, 26–28
Art Therapy (AATA), 218
Art Therapy (Gantt), 265, 270, 271
Art Therapy & Computer Technology (Malchiodi), 162
Art Therapy & Drama Therapy (Jennings), 163
Art Therapy & Group Work (Hanes), 111, 265
Art Therapy and the Third World, 256
Art therapy as Witness (Horovitz), 114
Art Therapy: Beginnings, xv
Art Therapy Credentials Board (ATCB), 141, 277
Art Therapy Has Many Faces (Rubin), 1, 41, 263–264
Art Therapy in a Children's Community (Kramer), 59, 242
Art Therapy in Mental Health, 265
Art therapy literature
bibliographies, 264–265
books on, 265–266
conference proceedings, 266
journals, 265
National Institutes of Mental Health (NIMH), 260
Art Therapy Outcome & Single Subject Studies, 83
Art Therapy Practice Analysis Survey, 142
Art Therapy: The Person-Centred Way, 100
Art Therapy with Families in Crisis (Linesch), 109
Art Therapy with the Unidentified Patient (Wadeson), 238
Art Versus Illness (Hill), 225
Artwork of children, 127–128
Asian art therapy, 67
Asia Pacific Art Therapy Center (Bangkok), 34, 67
Asperger's syndrome, 199
Assessment
aesthetics, 113
art, 1, 24
art and diagnosis, 119
art and older adults, 187
art and psychopathology, 125–126
art as tool in, 58
art batteries: couples, 139
art batteries: families, 139
art batteries: individuals, 136–137
art for, 31, 54
art in medical, 218–220
artistic development studies, 127–128
art process in evaluation, 84–85
art product in evaluation, 84
art therapists as diagnosticians, 128–129
art therapy intervention, 83
art used for understanding, 1
assessing sexual abuse through art, 138
change after group art therapy, 132–134
of clinicians effectiveness, 82–83
copying and completion, 121
Creative Analysts, 136
defined, 24
essence of art therapy, 27, 39
Face Stimulus Assessment, 141
integration graph, 136
Magazine Photo Collage, 140–141
overview, 134
of patient, 29, 34, 80
physically or mentally handicapped, 253n1
in planning/evaluation, 81
preference tests, 120
projective drawings, 122–125
projective testing, 119
and projective themes, 136
rating scales for art products, 129–132
reveals depth of pathology, 135
scribble drawing, 121, 135
series of tasks, 41
Silver Drawing Test of Cognition & Emotion (SDT), 139–140
sibling death, 11
for specific purposes, 137–138
spiritual development through art, 138
standardization in drawing tasks, 125
structured approaches, 137
unstructured approaches, 134, 137
uses of art in, 85
visual stimuli response, 119
Association des art-therapeutes du Quebec (AATQ), 277
Association Française de Recherches et Applications des Techniques Artistiques en Pedagogie et Medicine (France), 66
Attachment, 96
Attention deficit disorder, 157
Australian & New Zealand Art Therapy Association (ANZATA), 278
Authentic Movement (Virshup), 163
Authoritarian, 15
Authority figures portraits, 125
Autistic spectrum disorder, 194, 197
Autogenics, 148
Automatic drawing, 102
Auxiliary ego, 150

B

Barron-Welsh Art Scale, 120
Behavioral approaches, 103–104
Behavior during creative process, 81
Behavior modification, 104
Behavior therapy, 104, 148
Being-in-the-world, 102
Belief Art Therapy Assessment (BATA) (Horovitz), 114, 138
Bender Visual-Motor Gestalt Test, 121
Bereavement, 227–228
Beyond Words: Art Therapy for Older Adults (Rubin), 186, xvi
Beyond Words: Art Therapy with Older Adults (Rubin), 258
Bipolar (manic-depressive) disorder, 53, 192
Black Beat in Art Therapy Experiences, 256
Blind children
  art therapy with, 83, 204, 222
  group art therapy, 132
  with multiple disabilities, 32
  self-concept, 55
  therapeutic art program, 200–201
Board Certified (ATR-BC), 250
Board certified (ATR-BC), 260
Board Certified Registered Art Therapist (ATR-BC), 27, 38
Body image, 124, 128, 175, 219–220
Boss-slave game, 151–152
Boy That Time Forgot (MacGregor), 203
Bravery and creative coping, 191–194
Bridging the Silence (Simonds), 86
Brief Art Therapy Screening Evaluation (BATSE) (Gerber), 138
British Columbia Art Therapy Association, 278
British Association of Art Therapists (BAAT), 47, 64, 278
Bulimia, 207
Bulletin of Art Therapy, 202, 233, 265
Bulletin of Art Therapy (Ulman), 25, 61, 66

C

Canadian Art Therapy Association (C.A.T.A.), 278
Canadian Art Therapy Association Journal, 265
Cancer patients, 36, 224, 225n6, 226
Cancer Stories (Dreifuss-Katan), 226
Career in art therapy, 266–267
Care survey, 83
Cartoon drawings, 150, 153, 159
Cartoon Magic (Crowley), 150, 153
Center on Aging, Health, & Humanities, 186–187
Ceramics, 209
Cerebral hemispheric dominance, 85
Cerebral palsied adults, 202
Child Art, 55
Child Art Therapy, 38, 235
Childhood schizophrenia, 2, 194–197
Child Life, 225
Child Life Council (CLC), 38
Child life programs, 38
Children
  abandonment, 10
  aggression, 7, 12, 16, 195
  aggressive/regressive phase, 113
  alienated adolescents arts enrichment, 36
  and anger, 173, 232
  anger in drama, 15, 42
  and anxiety, 11–12, 13, 110
  and art, 2, 5–6, 41, 272
  art and refugee, 59, 229
  art and sick, 99
  and art sessions, 30
  and art therapy, 172, 176
  artwork of, 127–128
  attention deficit disorder, 157
  authority figures portraits, 125
  auxiliary ego, 150
  blind, 32, 55, 83, 132, 200–201, 204, 222
  body image distortions, 219–220
  borderline conditions, 86
  with cancer, 226
  cartoon drawings, 159
  Child Art, 55
  child life programs, 38
  colors of disaster, 231n10
  congenital glaucoma, 201, 202
  creative arts program, 35–36
  dance therapist, 33
  deaf, 31, 140, 141, 169, 203
  deaf-mute, 242–243
  dealing with death, 172
  and depression, 14, 161, 176
  and diabetes, 219
  with disabilities, 104, 107, 141
  dissociative episodes, 14
  and divorce, 9–11, 154, 176
  Dot-to-Dot drawing, 121, 147
  draw-a-person/self-portrait, 128–129
  and drawing, 97, 122, 128, 195
  drawing behavior, 127
  drawing books, 154
  drawings of, 125, 128, 137
  drawing workbooks and guides, 228
  and dreams, 3
  dyslexic, 203
  elective mute, 169–171
  with encopresis, 221–222
  enuresis, 221
  expressive art for, 56
  expressive arts therapy, 201–202
  expressive media, 161
  expressive modalities, 101

and extreme behavioral continuum, 173
and families mental health, 235
and fantasies, 201, 206
fantasy creatures, 196, 228
fantasy vs. reality, 11, 16, 236–237
and fears, 171
finger paints, 211
and foster homes, 232
and graphic secretary, 152
and group art therapy, 132–134
handicapped, 222
homeless, 37
individual growth in a group, 112–113
interpersonal environment, 136
jealousy, 6, 98, 196, 202, 236
loss of parent, 228
materials used by, 70–71
Mexican pottery clay, 211
miniature life toys, 158
multimodal expression, 46
with neurological impairment, 138
neurologically handicapped, 83
nightmares, 42, 107
oppositional behavior, 135
panic attacks, 12
and parent suicide, 228–229
and perception, 253–254
perceptual styles, 127
with physical disabilities, 31, 32
play therapy, 103
play vs. art therapy, 37–38
with polio, 222
with psychotic disorders, 194
and rage, 162
reaction-formation, 98
repressed anger, 170
retarded, 141, 156
saying goodbye, 10–11, 14, 43
school art therapy, 237–238
self-drawing, 128–129
self-help materials, 153
self-identification, 55, 150
sensory awareness, 150
server burns, 218
sexual abuse, 86, 138, 149, 186
sign language, 167
and solitary drama, 197–199
stuttering, 157
and suicide, 135, 161
tactile aesthetic, 254
traumatized, 37
values of arts for, 234
Children & the Arts, 36
Children and the Arts: A Film About Growing, 234
Children's Apperception Test (CAT), 120
Children's art, 54, 127
Child's Story (Harris), 209
Child study movement, 55
Child therapy
art and play therapy, 174
art in, 272
art therapy and art counseling, 38–39
cartoon drawings, 150
pediatric art therapy and child life programs, 38
play therapy and child art therapy, 37–38
sandplay, 172–173
Chinese healing techniques, 163
Chromatic, 124, 125
Chronic disease processes, 224
Clay
adults, 212
art, 115, 127, 150, 154, 169, 177
Client-centered approach, 100
Clinical art therapy, 25
Clinical psychology, 53, 119
Clinician
art for assessment, 31
art therapy diagnostics, 137
assessment effectiveness, 82–83
drawing and associative processes, 150
drawing signs in patients, 125
evocation of visual imagery, 148
family photographs, 159
field of psychotherapy, 27
framework for freedom, 76
individual performance, 125
projective drawings, 123
Clinician Award, 252
Coalition of Art Therapy Educators (CATE), 250
Cognition, 127
Cognitive, 93, 104–107, 105
Cognitive ability, 138
Cognitive-Behavioral approach, 106
Cognitive-behavioral methods, 12
Cognitive-behavioral therapy, 114
Cognitive/symbolic (C/S), 155
Cognitive therapy, 106
Collaborative vs. authoritarian model of psychotherapy, 102
Collective unconscious, 98
Color disintegration, 113
Color integration, 113, 136
Color therapy, 114
Common Boundary, 46, 274
Communication
and art, 21, 167
art and drama, 161
artwork and elderly, 187–188
with blocked supervisee, 247
image-talk, 53
international networking, 67
International Networking Group of Art Therapists (ING/AT), 66

mutual, 152
and perceived views, 110
Talking Book, 243
value of artistic product, 73
Community tensions, 231–232
Compulsive overeating, 207, 210
Compulsive self-injury, 192, 210, 214
Computerized data-bases, 265
Computers, 71, 162, 223n3, 265, 273–274
Conference on Arts for the Mentally Retarded, 206
Conference Proceedings, 279–280
Conference Proceedings (AATA), 203, 210, 231, 233, 248–249, 266
Confinia Psychiatrica, 265
Congenital glaucoma, 201, 202
Congressional Record, 258
Connection, 136
Conscience, 252
Constructivist approach, 107
Consultation, 237
Consumer Reports, 82, 83
Contact media, 220
Continuing education, 260–261
Continuing Education Credits (CECs), 250
Contour drawings, 147, 148
Copying and completion, 121
Counseling, 38–39, 56
Counter-transference, 152
Couples and drawing, 124, 139
Courage! Together We Heal (Anderson), 209
Crayons, 141, 147
CREATE (Toronto), 46
Create with art media, 69
Creating, For Me (Aach), 32n3
Creative & Expressive Arts Therapy (CEAT), 40, 46, 167, 168
Creative & Mental Growth (Lowenfeld), 55, 107
Creative analysis, 113
Creative Analysts, 136
Creative art activities, 238
Creative arts program, 35–36
Creative art therapies, 67
Creative expression, 37, 50, 87–88, 216
Creative Growth, 203
Creative Journal (Capacchione), 153
Creative level (CR), 155
Creative process
adults, 184, 213
with art materials, 173
and art therapy, 84
and behavioral approaches, 104
behavior during, 81
knowing the, 72
observing the, 79
and psychotherapy, 90, 116
self-representation, 175
symbolic speech, 91
Creative reframing, 102
Creative therapy, 47, 66
Creative Transformation (Lewis), 99
Creative work blocks, 183
Creative workbooks, 153
Creativity, 103, 247
Creativity & Madness (Panter), 53
Creativity and Aging Study, 187
Creativity and madness, 53
Creativity Mobilization Technique, 148
Credentialing in other areas, 267
Crisis intervention, 231
Custody evaluation, 232
Cutting. *See* Compulsive self-injury
Cybernetics, 109
Cybernetic theory, 105
Cystic fibrosis, 202

D

Dance therapist, 33, 100
Dance therapy, 79, 135, 163, 193–194
Day Treatment Programs, 186
Deaf children, 31, 140, 141, 169, 203
Deaf-mute children, 242–243
Death
adolescents, 182, 227
adults, 227
children dealing with, 172
dying patient, 225–226
imagery, 3–4, 110–111
Defense mechanisms, 96
Delinquent teenagers, 36
Dementia, 188
Dent-Kwiatkowska Rating Manual, 129
Depression
adults, 17, 147–148, 184, 210
children, 14, 161, 176
to dissociation, 210–215
Developing Cognitive & Creative Skills through Art (Silver), 105
Developmental approach, 107
Developmental Art Therapy (Williams), 107
Developmental orientation, 107
Developmental phenomena, 96
Developmental psychology, 127, 128
Diabetes, 219
Diagnosis and assessment tool, art, 142
Diagnosis and therapy in art, 53–54
Diagnostic art evaluation, 135
Diagnostic art interviews, 134
Diagnostic Drawing Series, 41, 130
Diagnostic Drawing Series (DDS), 137
Diagnostic goal, 155
Didactic presentation, 272

Directive approach, 157
Disabilities
  art education therapy, 55
  with children, 104, 107, 141
  and computers, 71
  educational/recreational settings, 31–33
  family of disable individual, 206
  history of art therapy for those with, 202–205
  interdisciplinary exchange, 52
  living with, 199–200
  medical art therapy/arts medicine, 34–35
  medical/rehabilitation settings, 33–34
  self-expression, 206
  teamwork, 35–37
Disability issues, 253–254
Displaced persons, 233
Dissociative episodes, 14
Dissociative identity disorder (DID), 42, 141, 163, 210, 214
Distinguished Service Award (DSA), 252
Disturbed adolescents, 116
Divorce, 9–11, 154, 176, 232
Domestic violence, 233
Dominant psychodynamic thinking, 109
Don Jones Assessment, 149
Doodle Diary techniques, 165
Dot-to-Dot drawing, 121, 147
Drama modalities, 199, 201–202, 221
Drama therapy, 30, 36, 40, 44
Dramatic play, 37
Draw-a-Man Test (Goodenough), 122, 128
Draw-a-person/self-portrait, 128–129
Draw-a-Person Test (DAP), 122, 125, 128
Draw-A-Story test, 140
DrawBridge, 37
Draw from Imagination, 140
Drawing
  art therapy, 41
  and associative processes, 150
  children, 97, 122, 128
Drawing and painting, 96, 114, 121, 151, 195
Drawing assessment, 128
Drawing behavior, 127
Drawing books, 154
Drawing dialogues, 151, 170
Drawing(s)
  of children, 125, 128, 137
  disease processes clues, 220
  self-rehabilitation, 223n2
Drawing tests, 122
Drawing themes, 124
Drawing Together (Kaplan), 151n4
Drawing types, 137
Drawing workbooks and guides, 153–154, 228
Dreams, 3
Dyadic (two-person) dynamics, 74
Dynamic Art Therapy, 145
Dynamic unconscious, 96
Dyslexic children, 203

E

Early infantile autism, 194, 198
Earth Angels (McNiff), 113–114, 275
Easel Age Scale, 128
Eastern Virginia Medical School, 246
Eating disorders, 207
Eclectic approach, 115
Economically disadvantaged individuals, 233–234
Education & Training Board (ETB), 250
Educational Program Approval Board (EPAB), 250
Educational/recreational settings, 31–33
Education and training
  Americans taught courses abroad, 67
  apprenticeships/courses/training programs, 245–246
  art classes, 238
  art therapists, 27–28, 118
  art therapy and counseling, 39
  art therapy requirements, 260
  Art Therapy: The Person-Centred Way, 100
  art therapy training programs, 44–45, 101
  board certification standards, 250
  career in art therapy, 266–267
  child life specialist, 38
  continuing education, 260–261
  creation of programs overseas, 66
  credentialing in other areas, 267
  educational aspects of art therapy, 37
  educational requirements, 251
  education program standards, 250
  employment/funding sources, 267–270
  evolution of art therapy, 241
  evolution of standards, 249
  expressive therapies training program, 115
  graduate training program in art therapy, 62–63
  images of supervision, 247
  in-service training, 77
  learning by doing, 241–242
  learning by sharing with others, 243
  learning by teaching and consulting, 242
  learning through further education, 250–251
  in mental health, 41
  obtaining relevant credentials, 251
  personal psychotherapy/supervision learning, 243–245
  professional identity formation, 248–249
  progressive education, 55
  promoting creativity in art therapist, 247–248
  psychotherapy, 27
  self-awareness, 246–247
  standards for registration, 249–250
  supervision, 246

training issues, 45–46
training program, 263
translating English books, 67
Education of All Handicapped Children Act (1975), 204, 206
Education Standards, 250
Ego-building potential, 97
Ego ideal, 252
Ego psychology, 59
Eight-Figure Redrawing Test, 123–124
Elaine's Art & Therapy Autobiography, 210–213
Elderly, 184–186, 187–188, 202, 204
Elective mute, 1, 151, 169–171
Emerging Body Language (EBL) Therapy, 197
EMI (Expressive Media Inc.), 186, 234, 265
Emotional distress, 217
Emotions, 18
Empathy, 100
Employee Assistance Program (EAP), 238
Employment/funding sources, 267–270
Encopresis, 5, 6, 221–222
Enuresis, 221
Epaminondas and His Auntie, 247
Ericksonian approaches, 102
Ethical Principles for Art Therapists, 252, 253
Ethics
confidentiality and exhibitions, 253
ownership and storage, 253
provocative images, 252
standards of practice and ethical conduct, 251–252
Ethics and client/therapist differences
disability issues, 253–254
multicultural issues, 255–257
phenomenological research on tactile aesthetic, 254
Ethology, 116
European Advisory Board of National Art Therapist Associations, 66
European Consortium for Arts Therapies Education (ECArTE), 66
Every Person's Life Is Worth a Novel (Polster), 180
Evocative technique, 149
Evoking and facilitating expression, 78
Evolution of art therapy, 146, 241
Evolution of standards, 249
Exhibitions of patient art, 59
Existential Art Therapy (Moon), 102
Existentialism, 102–103
Existing, 102
Express feelings/fantasies, 192
Expressionism and Surrealism, 51, 55
Expression of Healing (Graves), 228
Expressive analysis, 25
Expressive art for children, 56
Expressive Arts Therapy Programs, 229
Expressive art therapy, 42–43, 201–202
Expressive media, 161
Expressive modalities, 42–43, 101
Expressive or creative therapies, 46
Expressive Therapies Continuum (ETC), 71, 155
Expressive therapies training program, 115
Expressive therapy, 25, 45, 163, 173, 207
Extreme behavioral continuum, 173
Eye Movement Desensitization (EMDR), 164

F

Face Stimulus Assessment, 141
Family Art Diagnostic, 139
Family art evaluation, 29, 77, 139, 152, 206, 207
Family art therapy, 109–111
and adolescent roll in family, 175
and divorce, 232
domestic violence, 233
and sexual abuse, 209
systemic approach to art therapy, 107
tasks to help family, 157–158
Family assessment batteries, 139
Family-Centered Circle Drawing, 124
Family Clay Sculpture, 139
Family Creative Arts Center, 237
Family disruptions, 232
Family Drawing, 124
Family group, 124
Family of disable individual, 206
Family photographs, 159
Family preservation, 232
Family Sculpture, 165
Family theme, 110
Family therapy, 107
Family Therapy & Evaluation Through Art (Kwiatkowska), 109
Fantasies, 176, 201, 206
Fantasy creatures, 7, 13, 15, 196, 228
Fantasy vs. reality, 11, 16, 236–237
Fears, 87, 162, 171, 176
Federation Française des Arts-Therapeutes (France), 66
Feedback, 105
Fighting cancer with art and imagery, 226–227
Film animation, 160
Film Award, 252
Films
adolescents, 206
Anna Shafer & Her Art, 186
Arts as Therapy for Children, 36
Art Therapy Has Many Faces (Rubin), 263–264
Beyond Words: Art Therapy for Older Adults (Rubin), 186
Beyond Words: Art Therapy with Older Adults (Rubin), 258
Children & the Arts, 36

Children and the Arts: A Film About Growing, 234
Courage! Together We Heal (Anderson), 209
Creating, For Me (Aach), 32n3
Green Creature Within, 44
Hands, 39
Kidzone TV, 223
In Living Color, 256
Make Your Mark With Art, 186
Maurice Falk Medical Fund, 260
The Maze, 191
Mister Rogers' Neighborhood (PBS), 222, 235, **236**, 242, 274
Passionate Visions (Yelen), 188
photograph, and art with ghetto adults, 234
Portrait of Pleasure Endeavors, 186
slides and, 160, 161
Three Faces of Eve, 210
We'll Show You What We're Gonna Do!, 32
We'll Show You What We're Gonna Do!, 234
Finger paints, 53, 54, 127, 148, 211
First World War, 229
Focusing-Oriented Art Therapy (Rappaport), 100
Fold-over drawing game, 152
Formal Elements Art Therapy Scale, 122
Formal Elements Art Therapy Scale (FEATS) (Gantt), 130
Formulaic approaches, 141
Foster homes, 232
Free art, 146
Free Arts for Abused Children (FAAC), 37, 232
Free association, 3, 97–98, 149, 150, 227
Free choice procedure, 103, 134, 157
Free expression, 96
Free Flow Technique, 147
Free will, 103
Freudian object relations theory, 99
Freudian Psychoanalysis, 96–97

G

Genogram, 124
Gerontologist, 186
Gestalt approaches, 101, 111
Gestalt Art Experience (Rhyne), 101
Gestalt therapist, 46, 101
Gesture drawings, 147
Global ratings, 125
Goal(s)
art activity, 28, 35
art therapists, 117, 165
of intervention, 145, 155
process of change in therapy, 76
therapy vs. education, 37
Goodenough-Harris Scale, 128
Government Affairs Award, 252
Governmental Affairs Committee (GAC), 258n3
Graphic imagery, 149
Graphic language, 141
Graphic materials, 127
Graphic secretary for child, 152
Green Creature Within (Irwin), 44, 160, 179
Grief support groups, 227–228
Group analytic tradition, 112
Group art therapy, 111–113
acceptance of disability, 200
art therapists, 29
blind children, 132
children and, 132–134
dominant psychodynamic thinking, 109
humanistic approaches, 111
multifamily, 209
sharing feelings and frustrations, 223
systemic approach to art therapy, 107
videotaping, 160
Group dynamics
dominant psychodynamic thinking, 109
educational requirements, 251
for staff development, 238
Tavistock method, 112
understanding of, 111
Group interactive art therapy, 112
Group or family therapy, 89
Group process, 111
Group psychotherapy, 40, 112
Group therapy, 168
Guided Imagery in Music (GIM), 159
Guided imagery with drawing, 149
Guidelines (AATA), 250
Guidelines for Art Therapy Training, 264
Guide to Art Therapy Assessment (Brooke), 128
Guide to Conducting Art Therapy Research (Wadeson), 83, 134

H

Hallucinations, 85
Handbook of Art Therapy (Malchiodi), 64
Handbook of Clinical Intervention in Child Sexual Abuse (Sgroi), 209
Handicapped children, 222
Hands, 39
Haptic perception, 253
Head trauma patient, 218
Healing, therapy for, 224–225
Healing and natural beauty, 49
Healing power
of art, 26, 34, 35, 69, 118, 274–275
of imagery, 224
Healing process, 92
Health Professionals Network (HPN), 260
History of art therapy, 202–205
History of Art Therapy in the United States (Junge), 64

Holding environment, 213, 214
Holistic, 100
Holistic hemisphere, 167
Home for Crippled Children (now Children's Institute), 202, 242
Homeless children, 37
Honorary Life Membership (HLM), 252
Hospital Audiences, Inc. (HAI), 33
Hospital Drawing Book, 154
Hospital Drawing Book (Rubin), 38
House-Tree-Person Test (H-T-P), 122n3, 124, 128
Human figure drawing, 124
Human Figure Drawings (HFDs), 125, 128
Human Figure Drawings in Adolescence (Schildkrout), 125
Human immune system, 226
Humanistic approaches
  vs. adaptive, 107
  Adlerian, 100–101
  connect, 102
  Ericksonian, 102
  Existentialism, 102–103
  Gestalt, 101
  group art therapy, 111
  person-centered approach, 100
  phenomenological, 102
Human potential movement, 100, 101
Human psychology, 74
Human spirit, expression of, 226
Hypno-Art Therapy, 158
Hypnosis, 102, 149, 158–159

I

Ideas and feelings, 1, 3, 14, 30
Identify graphic clues, 125
Identity formation, 179
IEP (individualized educational plan), 75, 81
Illness, 218, 219, 224
Imagery
  to bypass defenses, 41
  and death, 3–4, 110–111
  and emotions, 18
  free association, 3, 97–98
  free expression of, 96
  hallucinations, 85
  healing power of, 224
  and human immune system, 226
  ideas and feelings, 30
  and information processing, 106
  patient associations to, 97
  psychology, 148
  psychotic, 53
  source of, 51
  verbal associations to, 135
  violent or provocative, 252
  visual symbols, 98
  Visual Thinking, 86
  visual thinking process, 5
Image-talk, 53
Imagination, 115
Imagination, Cognition, & Personality, 148
Individual art therapy, 1, 179, 191, 192, 194, 209
Individual assessment batteries, 136–137
Individual growth in a group, 112–113
Individual psychology, 100
Individuals with Disabilities Education Act (IDEA), 204
Information processing, 106
Inkblots, 120
Inscape (Great Britain), 265
In-service training, 77
Insight, 96
Institute of Group Analysis, 112
Instructional aid, 297–316
Integration graph, 136
Integrative approaches, 115–116
Integrative Approaches to Family Art Therapy (Riley), 109
Intentionality, 103
Interdisciplinary exchange, 52
Interface, 78–80
Intermodal approach, 115
Intermodal understanding, 45
Internal feelings, 87
Internal psychological integration, 88
International Conference on the Creative Arts Therapies, 66
International Expressive Arts Therapy Association (IEATA), 45, 267, 278
International Imagery Association, 105, 148
International networking, 67
International Networking Group of Art Therapists (ING/AT), 66, 266, 278
International Phototherapy Association, 159
International School for Interdisciplinary Studies, 45
International Society for Psychopathology of Expression and Art Therapy, 52
International Society for the Psychopathology of Expression (SIPE), 52, 62, 265
International Society for the Psychopathology of Expression & Art Therapy (SIPE), 278
Interpersonal dynamics, 74
Interpersonal environment, 136
Interpersonal group therapy, 112
Interpersonal information and art, 139
Interpersonal phenomena, 96
Interpersonal situation, 124
Interpretation, 152
Inter-rater reliability, 125, 132
Intervention, modes of, 85
Intra-individual variability, 127

Intrapsychic dynamics, 74
Intuitive approach, 117

J

Jealousy, 6, 98, 196, 202, 236
Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), 260
Joint nonverbal drawing, 151
Joseph P. Kennedy Jr., Foundation, 206
Journal of Mental Imagery, 105–106, 148
Journals, 165, 265, 279
Jungian Analytical Psychology, 96
Jungian Analytic Therapy, 98–100

K

Katrina Through the Eyes of Children, 231
Kidzone TV, 223
Kinesthetic, 91
Kinesthetic/sensory (K/S), 155
Kinetic Family Drawing (KFD), 124, 128
Kinetic House-Tree-Person Drawing, 124
Kinetic School Drawing (KSD), 125
Kinget Drawing Completion Test, 121

L

Leap of Faith (Horovitz), 114
Learning by doing, 241–242
Learning by sharing with others, 243
Learning by teaching and consulting, 242
Learning experiences, 7–9, 90
Learning through further education, 250–251
Legal and ethical issues, 252
Leukemia, 199, 226
Life Line, 88, 164
Life? or Theater? (Salomon), 229
Life Paints Its Own Span (Bach), 220
Life Review (Ulman), 184
Life Space, 88
Life Space picture, 164
Linear, 113
Linear hemisphere, 167
Line drawings, 120
Living Color
  Films, 256
Loss of loved ones, 228
Loss of parent, 228
Lou Gehrig's Disease, 224
Luscher Color Test, 120
Lymphoma, 225

M

Magazine Photo Collage, 140–141, 147
Magazine Photo Collage (Landgarten), 257
Magical visual symbols, 50
Make-Believe Drawing Book, 154
Make Your Mark With Art, 186
Mandala, 100, 120, 192
Manner of working, 155
MARI Card Test, 120
Marriage stress, 158
Martin Luther King Freedom School, 231
Massive, 113
Maurice Falk Medical Fund, 260
The Maze, 191
Media, 155, 175, 237
Media arts, 160
Media dimensions variables, 155
Medicaid, 192
Medical and rehabilitation settings, 33–34
Medical art therapy, 218
Medical art therapy/arts medicine, 34–35
Medical/rehabilitation settings, 33–34
Medicine men and shamans, 50
Medium and style, 22
Memories, 86
Menninger Perspective, 139
Mental health
  art primary prevention, 217
  art therapy trailblazers, 61
  care survey, 83
  for children and families, 235
  color integration, 113
  and creativity, 103
  everyday life, 235
  medical and rehabilitation settings, 33–34
  normal adults, 238
  and pictorial diagrams, 124
  schizophrenia, 167–168
  training in, 41
  treatment planning, 81
  values of arts for children, 234
Mental Health Systems Act, 259
Mental hospitals, 64
Mental illness
  bipolar disorder, 192
  creativity and madness, 53
  and outpatient art groups, 193
  paranoid delusions, 181
  psychiatric interest in patient art, 51–52
  psychiatric treatment centers, 61
  psychotic disorders, 191
  and spontaneous art, 80, 167
Mental imagery, 148–149, 224
Mental Imagery (Nucho), 105n3
Mexican pottery clay, 211
Mind-body connection, 220
Miniature life toys, 158
Minstrels of the Soul (Knill), 115
Mirroring, 97, 197

Mister Rogers' Neighborhood (PBS), 222, 235, **236**, 242, 274
Modality, 37, 43–44, 76
Mother-and-Child Drawings, 124
Mother-child art group, 206
Mother's group, 206
Motivational techniques
  Adolescents, 150
Mourning, 5
Mt. Sinai's Child Life & Creative Arts Therapy Department, 223
Multicultural Committee (MCC), 256–257
Multicultural issues, 255–257
Multi-family art therapy, 110
  Group art therapy, 209
Multifamily group art therapy, 206, 209
Multimodal approach, 45, 46–47, 115, 163, 164
Multimodal expressive arts therapy, 163–164
Multimodal expressive therapies approach, 46
Multimodal group, 44
Multimodality approach, 100
Multimodal use of expression, 101
Multiple disabilities, 32
Multiple family art therapy, 232
Multiple modalities, 42
Multiple personality disorder (MPD). *See* Dissociative identity disorder (DID)
Multiple sclerosis, 224
Murals, 57, 111, 175
Murals of the Mind (Harris), 111
Music, 187
Mutual communication, 152
Mutual resentment, 157
Mutual Storytelling Technique (Gardner), 107
My Italian Journey (Goethe), 68
My Mom and Dad Don't Live Together Anymore (Rubin), 38, 154

N

Naive or primitive art, 53
Narrative therapy, 97
National Art Education Association, 205, 260n5
National Center for Complementary & Alternative Medicine, 225
National Child Research Center, 238
National Coalition of Creative Arts Therapy Associations (NCCATA), 45, 258–259, 260, 278
National Committee*Arts for the Handicapped (NCAH), 205, 206, 260
National Institutes of Health (NIH), 225, 259
National Institutes of Mental Health (NIMH)
  adolescents with schizophrenia, 109
  and apprenticeship, 245
  Art Therapy (Gantt), 265
  Art Therapy in Mental Health, 265
  art therapy literature, 260
  family assessment batteries, 139
  and patient art, 126
  rating scales, 129
  seminal work in family therapy, 62
  study on art therapy in institutions, 234–235
National Vietnam Veterans Art Museum, 230
Natural disaster and violence, 231
Natural Way to Draw (Nicolaides), 147
Necessary Losses (Viorst), 10
Negative ideas and feelings, 86
Netherne Hospital, 64
Neurobiology, 74
Neurological impairment, 138, 198
Neurologically handicapped, 83
Neuroscience, 114
New Orleans Museum of Art, 231
Newsletters of the International Networking Group of Art Therapists, 67
Nightmare Help (Wiseman), 107
Nightmares, 42, 107
Non-directive approach, 156, 157
Nondominant hemisphere, using, 147–148
Normal adults, 238
Normalization, 107

O

Objective handicap, 203
Object relations, 96, 97
Occupational therapy (OT), 39, 40, 47
Oedipal wishes, 110
Older Americans Act, 186
Omega, 238
Ontario Art Therapy Association (OATA), 279
Open-ended approach, 134
Open studio, 103, 111, 233
Oppositional behavior, 135
Organic impairment, 218
Organ transplant recipients, 225
Outpatient art groups, 193
Outsider art, 53
Ovarian cancer, 226
overseas programs, creation of, 66
Overt behavior, 103

P

Pain, 3, 18, 22
Painful reality, 21
Painting & Personality (Alschuler), 127
Painting and drawing, 61, 226
Painting Out Illness (Hill), 225
Painting therapy, 114
Panic attacks, 12
Paranoid delusions, 181
Paranoid schizophrenic, 52

Parent-child dyad art therapy, 110
Parent Play, 235
Parents & Children Together, 232
Parents' Self-Centered Circle Drawing, 124
Parent suicide, 228–229
Passionate Visions (Yelen), 188
Passive-aggressive fashion, 13
Patient art
  abstraction to representation, 177–178
  Art for Life, 225
  artists in hospitals, 56–57
  color integration, 136
  confidentiality and exhibitions, 253
  exhibitions of, 59
  Katrina Through the Eyes of Children, 231
  National Institutes of Mental Health (NIMH), 126
  ownership and storage, 253
  review for closure, 196
  and spontaneous art, 126
  treatment and the mind, 218
Patient risk, 215–216
Patients
  acutely psychotic states, 167
  assessment of, 29, 34, 80
  respect for, 252, 253
  who are resistant, 169
  who have no words, 167–168
Patterns That Connect (Rhyne), 101–102
Pediatric art therapy and child life programs, 38
People and families in crisis, 232
Perceived views, 110
Perception, 253–254
Perceptual/affective (P/A), 155
Perceptual styles, 127
Perinatal death, 227
Personal Construct theory, 101, 106
Personality/psychological functioning theories, 75
Personal psychotherapy, 246
Personal psychotherapy/supervision learning, 243–245
Person-centered approach, 100
Person-centered art therapy, 117
Person-centered therapy, 116
Person Picking an Apple From a Tree (PPAT), 122, 130
Pervasive developmental disorder, 198
Phenomenological, 102, 126, 254
Phenomenology, 102
Photo-Art Therapy (Corbit), 100
Photo-Art Therapy (Fryrear), 159
Photo collage, 140–141, 147
Photographs, 229–230
Photography program, 36
Phototherapy, videotherapy, and computers, 159–161
PhotoTherapy Centre, 159
Physical disabilities, 31, 32
Physically or mentally handicapped, 253n1
Physical trauma, 222
Pictorial diagrams, 124
Pictorial diagrams of interpersonal relationships, 124
Pictorial stimuli, 147
Pictorial storybooks, 198
Pictures of a Childhood (Miller), 209
Pied Piper Effect, 71, 152
Pittsburgh Association for the Arts in Education & Therapy (PAAET), 46
Pittsburgh Child Guidance Center (PCGC), 201, 234, 235, 243, 244, 251
PL 101-476. *See* Individuals with Disabilities Education Act (IDEA)
PL 94-142. *See* Education of All Handicapped Children Act (1975)
Play therapy, 46, 100, 103
Play therapy and child art therapy, 37–38
Plying the Sacred Circle (Henley), 115
Polaroid photography, 159
Polio, 204, 222
Political action and networks, 258–260
Political violence survivors, 231
Portrait of Pleasure Endeavors, 186
Post-drawing interrogation (PDI), 125
Postmodernism, 97
Posttraumatic stress disorder (PTSD), 86, 153, 230, 231, 232–233
Preference tests, 120
Prestructured Elements, 147n2
Primary goal therapy, 27
Primary prevention, 238
Primary-process image-talk, 168
Process-Centered Art Therapy, 107, 117
Product-Centered Art Therapy, 107, 117
Professional Quality Credits (PQCs), 249
Progressive disorders, 224
Projective drawing assessment, 141
Projective drawings, 122–125, 123, 128, 137
Projective Drawings (Hammer), 123
Projective drawing tasks, 138
Projective hypothesis, 119n1
Projective Methods (Frank), 127
Projective testing, 53, 119
Projective themes, 136
Project Zero, 127
Promoting creativity in art therapist, 247–248
Provocative images, 252
Psychiatric interest in patient art, 51–52
Psychiatric treatment centers, 61
Psychiatry and Psychology in the Visual Arts & Aesthetics (Kiell), 264
Psychimagery, 149, 158
Psycho-aesthetics, 25

Psychoanalysis
art used in, 59
dangers of repression, 55
field of, 58
free art, 146
inkblots, 120
unconscious, illogical thought, 52
and understanding, 96
Psychoanalytic ego, 113
Psychoanalytic Perspectives on Art (Gedo), 52
Psychoanalytic theory, 58
Psychobiological approaches, 114
Psychocybernetic Model of Art Therapy (Nucho), 105
Psychodrama, 163
Psychodynamic approaches, 96–100, 107
Psychodynamics, 74
Psychodynamic therapists, 41
Psycho-educational approaches, 103–107, 168
Psychoeducational orientation, 31
Psychogram, 136
Psycho-Iconography (Brown), 125
Psychological conditions, 77–78
Psychological framework, 77–78
Psychology
applied to art, 34
of art, 47
art therapists and, 83, 118, 244
art therapists trained in, 35
child life specialist, 38
of children's art, 54, 127
cognitive, 105
cognitive-behavioral therapy, 114
field of clinical, 53, 119, 267
Gestalt, 101
human, 74
and imagery, 148
individual assessment batteries, 136–137
master field of, 27
neuroscience, 114
and patient's products, 51
phenomenological, 102
psychoanalytic ego, 113
rating scales, 129
understanding of, 26
Psychoneuroimmunology, 224n5
Psychopathology, 75, 126, 146
Psychopathology of Expression, 52
Psychosis, 192–193
Psychosomatic conditions, 220–221
Psychotherapy
art normalizes, 89
and art therapists, 35, 75
art therapy and, 40–42
art vs. verbal, 88
being-in-the-world, 102
collaborative vs. authoritarian model of, 102
and counseling, 38–39
and creative process, 90
creative process, 116
and elderly, 185
and finger painting, 54
training and education, 27
understanding of, 26
Psychotic disorders, 191, 194
Psychotic imagery, 53
Psychotic regression, 180
Publications, 265, 279. *See also* Journals
Public awareness of art therapy, 260
Puppets, 199

Q

Qualitative evidence, 82–83
Quantitative evidence, 83
QuickDraw, 93

R

Rage, 162
Railing Against the Rush of Years (Ridker), 184
Rating scales for art products, 129–132
Rational-emotive therapy (RET), 105
Rationalization in verbal psychotherapy, 16
Reaction-formation, 98
Reality shaping, 104
Real therapy (group psychotherapy), 40
Re-Enchantment of Art Therapy (Kapitan), 115
Reframing, 118
Refugee adults, 233
Refugee children, 59
Registered Art Therapist (ATR), 27, 37, 249, 250, 260
Regressive media help with shame, 148
Relational approaches, 96
Relational psychoanalysis, 97
Reliability, 125
Reliable, 84
Remedial approach, 107
Remedial Art (Pacey), 265
Remediate psychological problems, 35
Renfrew Center, 207
Repetition compulsion, 103
Repressed anger, 170
Repression dangers, 55
Research Committee of the American Art Therapy Association (AATA), 83
Respect, 252, 253
Respiratory medicine centers, 220
Retarded
adults, 199
children, 141, 156
Rheumatoid arthritis, 220

Rogerian therapy, 101
Rudolf Arnheim Award, 252

S

Saber-Tooth Curriculum (Benjamin), 247–248
Sandplay, 99, 158, 172–173
Saying goodbye, 10–11, 14, 23–24, 43
Scapegoat, 116
Schizophrenia
  adolescents with, 109, 176–179
  artist-self, 151
  children, 127
  evoking and facilitating expression, 10, 78
  mental health, 167–168
  pictorial stimuli, 147
School art therapy, 237–238
Scream, The (Munch), 51
Scribble drawing
  art, 135, 147, 149, 155, 186, 228
  assessment, 121, 135
Secondary prevention, 217, 231, 238
Second World War, 230, 238
Secret World of Drawings (Furth), 220
Selective eclecticism, 117
Self-actualization, 100
Self-awareness, 151, 246–247
Self-concept, 55, 218
Self-consciousness, 88
Self-definition, 175, 186, 235
Self-destructive behaviors, 181
Self-development, 238
Self-drawing, 128–129
Self-esteem
  art expression for, 235
  art-making, 91
  children, 37
  enhanced sense of, 28, 35, 155, 209
Self-expression, 37, 206
Self-help materials, 153
Self-identification, 55, 150
Self-image, 178
Self-portrait, 186
Self-projections, 122
Self Psychology, 96, 97
Self-rehabilitation, 223n2
Self-reflection, 88
Self-representation, 175
Self-taught artist, 188
Self-therapy, 218, 225, 230, 235
Seminal work in family therapy, 62
Sense of Self, 186
Sensorimotor aspects of working in art, 221
Sensory, 91
Sensory awareness, 150
Sequential graphic Gestalt, 149
Server burns, 218
Sexual abuse, 86, 138, 149, 186, 209
Shamanism and ancient healing rituals, 45
Shame, 148
Shy, 135, 176
Sign language, 167
Silver Drawing Test (Silver), 130
Silver Drawing Test of Cognition & Emotion (SDT), 139–140
Sibling death, 11
Social Atom, 124
Social constructionism, 97
Social Security benefits, 193
Society for the Arts in Healthcare (SAH), 34n5, 225, 260, 267
Sociogram, 124
Solitary drama, 197–199
Solution-Focused approach, 107
Something to Draw On (Ross), 238
Speech therapist, 220, 243
Speech therapy, 196
Spinal cord injuries, 223
Spiritual approaches, 113–115
Spiritual Art Therapy (Horovitz), 114
Spiritual development through art, 138
Spiritual health, 90–91
Spirituality, 114
Spirituality & Art Therapy (Farrelly-Hansen), 115
Spontaneous art, 80, 126, 167
Squiggle Game (Winnicott), 121
Standardization in drawing tasks, 125
Stimulus Drawing Cards, 140
Stimulus drawings, 146, 147
Storytelling Card Game (Gardner), 120
Stressful situations, 217
Stroke damage and tasks, 137–138
Stroke patients, 147, 218
Structured approaches, 137
Studio art therapy, 113
Stuttering, 157, 220
Style, elements of, 113
Subjective handicap, 203
Sublimation
  art and destructive urges, 90–91
  ego-building potential of, 97
  higher level of, 28
  integration of conflicting feelings, 58
  through creative process, 96
Substance abuse, 207–209
Suicide, 135, 161, 172, 210
Sullen adolescents, 135
Superego, 252
Support groups, 206
Sybil (Schreiber), 210
Symbolic communication, 25
Symbolic control, 3
Symbolic expression, 50, 74
Symbolic expression of feelings, 199–200

Symbolic messages, decoding, 134
Symbolic speech, 58, 73, 91
Symbolism, 96, 97, 136, 199, 213, 229
Symbolization, 98
Systemic approaches, 107–109
Systems theory, 109

T

Tactile aesthetic, 254
Talisman, as art, 116
Talking Book, 243
Talk therapy, 212
Task analysis, 40
Task Panel on the Arts in Therapy & Environment, 260
Tavistock method, 112
Teamwork, 35–37
Techniques
  art and film therapy, 161–162
  artistic interventions, 150–153
  deciding what to do and why, 154–157
  Doodle Diary, 165
  drawing workbooks and guides, 153–154
  evolution of art therapy, 146
  Family Sculpture, 165
  hypnosis and guided imagery, 158–159
  introduction, 145–146
  Journal, 165
  Life Line, 164
  Life Space picture, 164
  mental imagery, 148–149
  motivational, 150
  multimodal expressive arts therapy, 163–164
  nondominant hemisphere, using, 147–148
  phototherapy, videotherapy, and computers, 159–161
  pictorial stimuli, 147
  regressive media help with shame, 148
  sandplay, 158
  series of images, 149–150
  specific tasks help family, 157–158
  stimulating materials and methods, 148
  visual starters, 147
  warming up, 146–147
Techniques for Individual and Group Art Therapy (Ulman), 155
Tempera markers, 71
Terminal illness, 225–226
Test-retest reliability, 125
Thematic Apperception Test (TAT), 120
Theme, 155
Theoretical approaches, 24
Theorists as art therapists, 116–117
Therapeutic, 27, 54–56
Therapeutic art activities, 26
Therapeutic art educators, 242
Therapeutic art program, 200–201
Therapeutic aspects of art education, 37
Therapeutic benefits of art, 89, 92
Therapeutic dyad, 75–76
Therapeutic goal, 155
Therapeutic power of art, 2, 5–6, 23, 34, 36, 187
Therapeutic process, 60, 146
Therapeutic recreation, 40
Therapy
  for all types of crises, 239
  and anger management, 215
  art as central modality in, 47
  art for life, 275
  for artists, 183
  for bereavement, 227–228
  chronic disease processes, 224
  community tensions, 231–232
  constructivist approach, 107
  crisis intervention, 231
  custody evaluation, 232
  defined, 25
  depression to dissociation, 210–215
  displaced persons, 233
  dissociative identity disorder (DID), 210
  eating disorders, 207
  economically disadvantaged individuals, 233–234
  and family disruptions, 232
  family preservation, 232
  grief support groups, 227–228
  group or family, 89
  for healing, 224–225
  and healing process, 92
  for helping, 1
  helps recovering addict, 209
  interpersonal information and art, 139
  interpersonal situation, 124
  knowing development, 74
  knowing pathology and potential, 75
  knowing psychodynamics, 74
  knowing the process of change in, 76
  knowing therapeutic dyad, 75–76
  knowing treatment planning, 75
  and mind-body connection, 220
  natural disaster and violence, 231
  and older adults, 184
  painting, 226
  people and families in crisis, 232
  physical conditions, 77
  Posttraumatic Stress Disorder (PTSD), 232–233
  primary prevention, 238
  psychoanalytic theory, 58
  psychological conditions, 77–78
  for psychosomatic conditions, 220–221
  qualitative evidence, 82–83
  quantitative evidence, 83
  secondary prevention, 231, 238

sexual abuse, 209
speech, 196
staff development, 238
and stressful situations, 217
substance abuse, 207–209
supportive setting, 76–77
for terminal illness, 225–226
in trauma and rehabilitation, 222–224
war and combat, 229–230
Therapy synthesis, 118
They Could Not Talk and So They Drew (Levick), 172
Third World Committee, 256
Three-Dimensional Apperception Test, 120
Three Faces of Eve (Sizemore), 210
Toronto Art Therapy Institute, 66
Traditional, 113
Tragedy, 22
Training and education. *See* Education and training
Training issues, 45–46
Training program, 263
Transactional object, 88
Transference, 75
Transformation, 100
Transitional object, 88, 202, 214
Transitions, 136
Transpersonal approaches, 114
Transpersonal psychology/psychotherapy, 100
Transplant patients, 220
Trauma, 41–42
Trauma and rehabilitation therapy, 222–224
Trauma survivors, 37
Traumatized children, 37
Treatment and the mind, 218
Treatment planning, 81
Triadic (three-person) dynamics, 74
Tuberculosis, 223

U

Ulman Personality Assessment Procedure (UPAP), 137, 139
Unconscious, illogical thought, 52
Understanding Children's Play (Hartley), 127
Understanding Children Through Their Drawings (Malchiodi), 271
Unfreezing, 146, 147
Universal language, 167, 233
Unresolved grief, 181–183
Unspoken perspective, 117
Unstructured approaches, 134, 137
Using Art in Trauma Recovery With Children (AATA), 232

V

Validity, 84, 125
Verbal associations, 135
Verbal fluency, 14
Verbal psychotherapy, 47, 84, 89
Verbal therapy, 1, 22, 84, 85, 169
Very Special Arts (now VSA Arts), 205, 260
Videotaping, 160. *See also* Films
Video technology, 161, 223
Videotherapy, 159, 160, 225
Vietnam veterans, 230
Vignettes
about, 1–2
art, drama and depression, 14–16
art, psychotic boy and reality, 5–6
art, writing, and reality, 21–24
art and aggression at home, 6–7
art and divorce, 9–11
art and marital therapy, 19–21
art and trauma, 3–5
art therapy, anxiety and security, 12–14
art therapy and anxiety, 11–12
art therapy and depression, 16–19
art therapy and grief, 11
art therapy and talented teenager, 14
expressive modalities, 42–43
Violent or provocative imagery, 252
Vision of 21st century art therapist, 270–271
Visual arts, 45, 158
Visual ideas, expression of, 71
Visual imagery, 148, 168
Visual impairment, 221
Visual languaging, 73, 153
Visually impaired, 254
Visual perception, 101, 253
Visual Preference Test, 120
Visual prompt, 147
Visual starter, 121, 147
Visual stimulation, 147
Visual stimuli response, 119
Visual symbols, 59, 98
Visual Thinking, 86
Visual Thinking (Arnheim), 105
Visual thinking process, 5
Visual treatment modality, 159
Volunteers, 37, 38, 231, 263

W

Walter Reed Army Medical Center, 230
War and combat therapy, 229–230
Warming up techniques, 146–147
War on Poverty, 35

Weaving program, 36
We'll Show You What We're Gonna Do!, 32, 234
Welsh Figure Preference Test, 120
Western Pennsylvania School for Blind Children, 200
Western Psychiatric Institute and Clinic (WPIC), 191, 192
Wheelchair Accessibles, 223
When Words are Not Enough (Levy), 46
When Words Have Lost Their Meaning (Abraham), 187
Witness writing, 103
Working artistically, 79–80
Working with groups, 115
Work places
  center for respiratory medicine, 220
  churches and funeral homes, 228
  clinics, hospitals, hospices, 225
  correctional institutions, 234–235
  institutions, 253
  medical hospitals, 222
  preschool, 235–238
  rehabilitation institutes, 222
  and secondary prevention, 217
  shelters, 233
  tuberculosis sanatorium, 218
  Veterans Administration hospitals, 230
Works Progress Administration (WPA), 57, 233
World Health Organization (WHO), 75
Wounds of mind and body, 209

ART THERAPY

"Rubin knows the story-telling power of images, whether conveyed in words or pictures—moving or still. Students and professionals alike will enjoy this new edition with its clear, insightful writing, many illustrations, and an accompanying DVD to bring the topic of art therapy further to life."

—Randy M. Vick, MS, ATR-BC, LCPC, Associate Professor of Art Therapy, The School of the Art Institute of Chicago

"Richly illustrated by vignettes that illuminate theory and bring it into practice, Rubin retains the same lively, passionate, and accessible style of writing that was so refreshing in the first edition. This is a key text for both beginning and experienced art therapists."

—Diane Waller, PhD, Professor of Art Psychotherapy at Goldsmiths, University of London; author of *Group Interactive Art Therapy* and *Art Therapy and Progressive Illness*

"Rubin's revision of ***Introduction to Art Therapy*** is deeply intelligent and yet easily accessible. She clarifies complex issues and uses eloquent anecdotes to convey the power of art therapy. This text is a welcome overview of the field with enough detail to satisfy the most curious and exacting reader."

—Laurie Wilson, PhD, ATR-BC, Professor Emerita of Art Therapy at New York University; author of *Alberto Giacometti: Myth Magic and the Man*

"Rubin's comprehensive examination of this unique profession provides the overview that I and other therapists need."

—Louis W. Tinnin, MD, Professor Emeritus, West Virginia University; Psychiatric Consultant, Intensive Trauma Therapy, Inc.

Introduction to Art Therapy: Sources & Resources is the thoroughly updated and revised second edition of Judith Rubin's landmark 1999 text, the first to describe the history of art in both assessment and therapy, and to clarify the differences between artists or teachers who provide "therapeutic" art activities, psychologists or social workers who request drawings, and those who are trained as art therapists to do a kind of work which is similar, but qualitatively different. This new edition contains a DVD-ROM with over 400 still images and 250 edited video clips; an additional chapter describing the work that art therapists do; and new material on education with updated information on standards, ethics, and informing others. Most importantly, however, this book provides a definition of art therapy that contains its history, diversity, challenges, and accomplishments.

Judith Aron Rubin, PhD, ATR-BC, is a licensed psychologist and faculty member of the University of Pittsburgh and the Pittsburgh Psychoanalytic Center. She is a former president and honorary life member of the American Art Therapy Association, and she consults, lectures, and gives workshops across the country as well as abroad.

DVD AUDIO

Routledge
Taylor & Francis Group
www.routledgementalhealth.com
Printed in the U.S.A.
Cover design: Elise Weinger Halprin

ISBN: 978-0-415-96093-9
90000
9 780415 960939

an **informa** business